

**MENTAL HEALTH INTENSIVE CASE MANAGEMENT
(MHICM)
IN THE DEPARTMENT OF VETERANS AFFAIRS:
THE EIGHTH NATIONAL PERFORMANCE
MONITORING REPORT
FY 2004**



**Department of
Veterans Affairs**

**NORTHEAST PROGRAM EVALUATION CENTER
VA CONNECTICUT HEALTHCARE SYSTEM
WEST HAVEN, CONNECTICUT 06516**

**Mental Health Intensive Case Management (MHICM)
in the Department of Veterans Affairs:
The Eighth National Performance Monitoring Report -
FY 2004**

FINAL DRAFT

July 26, 2005

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Executive Summary

This is the eighth national report on the evaluation of the Department of Veterans Affairs Mental Health Intensive Case Management (MHICM) program, previously called “Intensive Psychiatric Community Care” or “IPCC”. MHICM is an innovative, experimentally validated approach to care for veterans with severe and persistent mental illness. Previous reports (Rosenheck et al., 1997; Neale et al., 1998-2004) have demonstrated that: 1) assertive community treatment is a cost-effective service for veterans with serious mental illness who are high users of VA inpatient resources; 2) MHICM benefits are maintained over the long-term (2-5 years); and 3) MHICM can be implemented and monitored in VA settings nationally. This report, which presents performance data for FY 2004 refers to early efforts and evaluations as “IPCC” and recent teams and data as “MHICM”.

The MHICM Program

VHA Directive 2000-034, issued on October 2, 2000, defined “Mental Health Intensive Case Management” and identified criteria for client entry, program operation and monitoring. MHICM teams seek to deliver high quality services that: 1) provide intensive, flexible community support; 2) improve health status (reduce psychiatric symptoms & substance abuse); 3) reduce psychiatric inpatient hospital use and dependency; 4) improve community adjustment, functioning, and quality of life; 5) enhance satisfaction with services; and 6) reduce treatment costs.

Extensive literature demonstrating that assertive community treatment (ACT) or intensive case management teams can improve clinical status and reduce psychiatric hospital use for people with serious mental illness has prompted researchers, practitioners and advocates to identify ACT as an essential evidence-based practice for this population (Drake et al., 2001, Phillips et al., 2001). MHICM teams modeled on ACT provide individualized services in the community for veterans with serious mental illness. MHICM services are organized around a core set of treatment elements described in VHA Directive 2000-034: 1) Intensity of contact; 2) Flexibility and community orientation; 3) Rehabilitation focus; and 4) Continuity and responsibility.

Dissemination and Team Structure

FY 2004 ended with 78 MHICM teams in operation, with at least a dozen more in development. VHA Directive 2000-034 specifies MHICM performance and outcome monitoring by the Northeast Program Evaluation Center (NEPEC), VA Connecticut Healthcare System. Data are presented here for 4,761 veterans who received MHICM services in FY 2004 from 71 teams with 10 or more clients that collected outcome data for the period. Of this group, 4,057 veterans (85%) had entry interview data, 2,805 (59%) had follow-up interview data, and 3,619 (76%) had clinical progress report data. Another 407 veterans entered MHICM from pre-existing case management programs, with a lower standard of client monitoring. Increases in the number of MHICM teams (+95%) and clients (+136%) since 1997 have had relatively little effect on program cost per client (+17%; \$7,105) or client-to-staff ratio (+2%; 12.5 per FTE) in FY 2004. At the same time, 49% of teams had fewer than 4.0 clinical FTE, the standard set forth in VHA Directive 2000-034, or had staff detailed to other services (16%).

Client Characteristics

Overall, 89% of MHICM veterans had a diagnosis of psychotic illness at entry and had spent an average of 80 days in the hospital in the previous year. Almost half of MHICM clients (44%) had been hospitalized for *more than two years* in their lives, with over two decades of illness since their

first hospital stay. Virtually all MHICM clients (94%) received VA and/or Social Security funds for their disability. A majority (55%) received VA compensation for a service-connected disability and half (47%) had a representative payee manage their funds. Clearly, this group of veterans is dealing with long-term illness and severe disability. Client characteristics have remained fairly stable since 1997, though pre-admission hospital days have declined by 41%, following overall VA trends.

Service Delivery

Altogether 88% of MHICM veterans were seen weekly or more frequently by MHICM team staff; 61% were seen for more than one hour per week; and 89% received the majority of their care in the community. MHICM clients had an average of 69 face-to-face contacts with MHICM staff during FY 2004, or 1.3 face-to-face visits per veteran weekly. Contacts in FY 2004 (1.33) were lower than 1997 (1.64) but comparable to FY 2003 (1.35). A total of 749 veterans (16%) were discharged from the program during the year and 137 veterans (3%) were transitioned to less intensive services after meeting criteria specified in VHA Directive 2000-034. On average, MHICM veterans had received services for 1,301 days or more than 3 1/2 years.

Outcomes

Veterans treated by MHICM teams showed average reductions in psychiatric hospital days of 30 days (71%) during their first six months in the program and proportionate reductions through 12, 18, and 24 month periods, all statistically significant. All but two teams reduced hospital use for all time periods. Outcome analyses found statistically significant improvements of 14% on clinician-rated symptoms (BPRS mean change: -5.72, $t=-17.34$, $p<0.0001$) and 13% on client-reported symptom severity scores (mean change: -0.22, $t=-16.65$, $p<0.0001$). Client-reported housing independence increased by 13% (mean change: +0.40, $t=16.22$, $p<0.0001$) and quality of life improved by 10% (mean change: +2.56, $t=18.68$, $p<0.0001$). MHICM veterans were significantly more satisfied with MHICM services relative to standard VA mental health care (+19%; mean change: +0.58, $t=23.08$, $p<0.0001$). This was reflected in higher satisfaction with overall VA mental health services at follow-up (+9%; mean change: +0.35, $t=12.70$, $p<0.0001$). FY 2004 client outcomes were comparable to FY 2003 levels and consistently higher (+11% to +117%) than 1997 values.

Adherence to Model Standards

Review of team reports and outlier values supports continued monitoring of team resources and performance and attention to staff training needs. VHA Directive 2000-034 established guidelines for MHICM team operation that have been translated into a set of minimum standards and monitored to identify performance outliers. Eighteen of seventy-one MHICM teams (25%) met all eight minimum program standards in FY 2004, comparable with 15 teams (24%) in FY 2003. A network planning initiative and quarterly circulation of monitoring data to network leaders, begun in FY 2001, continue to enhance the implementation of MHICM teams nationwide.

Conclusion

Development of MHICM in VHA has followed a model sequence of problem identification, program development, evaluation and dissemination (Rosenheck and Neale, 2001; Rosenheck, 2001). Careful implementation and sustained monitoring have resulted in effective community-based services for veterans with serious mental illness, a highly vulnerable population. MHICM has been successfully disseminated to more than 70 facilities and site-by-site monitoring data show it continues to provide effective and efficient services to several thousand deserving veterans in great need.

Acknowledgments

We dedicate this Eighth National Performance Monitoring Report to the thousands of veterans served by MHICM teams since 1987 and those with serious mental illness who have yet to benefit from community-based services. At this stage of the MHICM history, few veterans or family members are likely to read this report, to review program data with MHICM team members or to provide feedback that affects program operation. That is likely to change with implementation of the Mental Health Strategic Plan, as veterans and family members are invited to become partners through advisory groups and participate in evaluation, planning and service delivery in ways that reshape the nature of VHA and MHICM services.

This report and the successful dissemination of MHICM owe much to ongoing support from Mark Shelhorse MD, outgoing Acting Chief Consultant, and William Van Stone MD, Associate Chief Consultant for Psychiatry and Coordinator of SMI Veterans Programs, for the Mental Health Strategic Healthcare Group; Miklos Losonczy MD PhD and Steven Cavicchia PhD (Co-Chairs) and members of the SCMI Committee and its Consumer Council; and Paul Errera MD, who continues to advocate for community-based services for veterans with serious mental illness.

Implementation of MHICM teams within VA has also benefited from efforts on behalf of assertive community treatment by individuals in the public sector, including: William Knoedler MD, Deborah Allness MSSW, Mary Ann Test PhD and the Program for Assertive Community Treatment in Madison, Wisconsin; Claudia Wink-Basing MSW, Cheri Sixbey CSW and the Assertive Community Treatment Association, Inc.; Neil Meisler MSW and Alberto Santos MD from the Medical University of South Carolina; Fred Frese PhD, Elizabeth Edgar RN, Dottie Sayer, Bonnie Banks, June Judge, Jane Fyer, Moe Armstrong and the Veterans Committee from the National Alliance for the Mentally Ill; and the Center for Mental Health Services at the Substance Abuse and Mental Health Services Administration (SAMHSA).

At NEPEC, Bernice Zigler, Alexandra Ackles and the Office of Information Services under David Bruce continue to improve our data management and communication capabilities in the face of a rapidly growing client population. We thank them all for their patience and invaluable support.

List of Acronyms and Abbreviations

ACCESS	MICROSOFT OFFICE RELATIONAL DATABASE SOFTWARE
ACT	ASSERTIVE COMMUNITY TREATMENT (PROGRAM MODEL)
ADJ	ADJUSTED SCORE
AVG/MN	AVERAGE
BPRS	BRIEF PSYCHIATRIC RATING SCALE
BSI	BRIEF SYMPTOM INVENTORY
CM	CASE MANAGEMENT OR CASE MANAGER
CPR	CLINICAL PROGRESS REPORT FORM (NEPEC MONITORING FORM 39)
DSS	DECISION SUPPORT SYSTEM (VHA FISCAL SOFTWARE)
DX	DIAGNOSIS
FDF	FOLLOW-UP DATA FORM (NEPEC MONITORING FORM 37)
FTE	FULL TIME EQUIVALENT POSITION
FY	FISCAL YEAR
GAF	GLOBAL ASSESSMENT OF FUNCTIONING SCORE
GM+S	GENERAL MEDICINE AND SURGERY FACILITY
GTE	GREATER THAN OR EQUAL TO
HOU1	HOUSING INDEPENDENCE INDEX
IADL	INSTRUMENTAL ACTIVITIES OF DAILY LIVING
IDF	INITIAL DATA FORM (NEPEC MONITORING FORM 34)
IDF DATE	INITIAL DATA FORM DATE
IP	INPATIENT
MAX	MAXIMUM
MD	PHYSICIAN, PSYCHIATRIST
MH	MENTAL HEALTH
MIN	MINIMUM
NEPEC	NORTHEAST PROGRAM EVALUATION CENTER (WEST HAVEN, CONNECTICUT)
NP	FORMER NEUROPSYCHIATRIC FACILITY
NSC	NON-SERVICE-CONNECTED
OPC	OUTPATIENT CLINIC FILE (VHA OUTPATIENT AUTOMATED DATA, AUSTIN TX)
PTF	PATIENT TREATMENT FILE (VHA INPATIENT AUTOMATED DATA, AUSTIN TX)
PRE-ENTRY	PERIOD BEFORE ADMISSION TO MHICM
QOL	QUALITY OF LIFE SCALE
RN	NURSE
SAS	STATISTICAL ANALYSIS SYSTEM SOFTWARE
SC	SERVICE-CONNECTED
SSI	SOCIAL SECURITY SUPPLEMENTAL INCOME
SSDI	SOCIAL SECURITY DISABILITY INCOME
TX	TREATMENT
YR	YEAR
VERA	VETERANS EQUITABLE RESOURCE ALLOCATION (VA BUDGETING STRUCTURE)
VHA	VETERANS HEALTH ADMINISTRATION
VISN	VETERANS INTEGRATED SERVICE NETWORK (MULTI-SITE HEALTH SYSTEM)

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Chapter One: Mental Health Intensive Case Management in a Changing VA Health Care System

Changes in VA Mental Health Care

The closing years of the twentieth century confronted the Department of Veterans Affairs (VA) and other public mental health systems with the challenge of providing appropriate, humane and efficient care to people with serious mental illness. Despite closing 40,000 psychiatric hospital beds between 1957 and 1988, VA relied heavily on inpatient treatment through the 1990's, spending over 70% of its mental health budget on hospital care as recently as FY 1996 (Rosenheck, 1997).

In 1995, the Veterans Health Administration (VHA) began a fundamental reorganization of its structure and services in pursuit of a more comprehensive, integrated healthcare system, with enhanced priorities of customer satisfaction, cost efficiency, and accountability. Manifestations of change have included the introduction of data-based approaches to care and management, decentralization of VA administrative and budget authority to 22 veterans integrated service networks (VISNs), reallocation of healthcare resources, and a shift of focus from inpatient services to outpatient, community-based and electronic modes of care.

In mental health, organizational changes have prompted dramatic reductions in VA inpatient service use. Between Fiscal Years 1995 and 2004, lengths of stay in general psychiatry inpatient programs declined by 62% (from 32 to 12 days), and 6,006 general psychiatry beds (66% of the 1995 total {9,058}) were closed. These included 1,479 (84%) long-stay beds (occupied for more than 1 year) (Greenberg and Rosenheck, 2004). Inpatient mental health care continues to account for more than half of VA mental health expenditures (\$1.2B; 53.6%), despite a reduction of 20.2% since 1995, and there are signs that inpatient resources have stabilized after years of dramatic decline. In FY 2004, only 58 general psychiatry beds (2% of the FY 2003 total) were closed. Reductions in inpatient beds have been offset, at least in part, by significant expansion of outpatient and residential rehabilitation services. Between FY 1995 and 2004, the number of veterans receiving VA outpatient mental health services increased by 288,798 (52.3%) and the number of clinical contacts per treated veteran fell from 12.8 to 12.0 (-6.7%). Unadjusted for inflation, overall mental health expenditures have risen modestly since 1995, increasing by \$302M (13.0%) and falling from 15.6% to 10.8% (-31%) as a percentage of all VA clinical costs (Rosenheck, 1996; Greenberg and Rosenheck, 2004).

The shift from inpatient to outpatient mental health care in VA would be expected to have its greatest impact on those with the most severely disabling mental illnesses, veterans who have traditionally relied on hospital treatment, especially long-term hospital treatment -- veterans who perhaps can least tolerate rapid change. People with serious mental illness are among the "least well off" (Rosenheck et al., 1998) and most vulnerable, commonly falling prey to homelessness, substance abuse, profound social isolation, and vocational dysfunction (Grob, 1994). Ethicists (Callahan, 1995; Boyle, 1995) and services researchers (Rosenheck, 1999; Schlesinger, 1995; Schlesinger and Mechanic, 1993) have emphasized that core values in our society urge us not to neglect the most vulnerable citizens, and to recognize that their vulnerability earns them special claim on public

resources. Ethical and societal goals warrant careful attention to developing and monitoring quality mental health services, particularly for the most needy veterans.

Accountability and Monitoring

VA healthcare increasingly emphasizes value, customer service, and accountability and provides specific impetus for implementation and careful monitoring of community-based care (Kizer, 1998). VA values clearly underscore the need for alternatives to inpatient hospitalization and enhanced attention to accountability and customer satisfaction. The Veterans Eligibility Reform Act of 1996 (Public Law 104-262, Section 104), furthermore, committed VA to maintain its capacity to provide specialized services for the most vulnerable veterans and mandates review of leadership reports on capacity by the VA Under Secretary for Health's Special Committee for the Care of Severely Chronically Mentally Ill Veterans (the "SMI Committee"). In 1999, the Under Secretary approved a recommendation by the SMI Committee to make intensive case management programs such as IPCC more widely available for veterans with serious mental illness (Recommendation 3, SMI Committee, 1999). In 2000, his successor issued a directive (VHA 2000-034) that defined "Mental Health Intensive Case Management" services for veterans with serious mental illnesses.

Case Management and Assertive Community Treatment (ACT)

For several decades, mental health clinicians and researchers, dismayed by the adverse consequences of precipitous State Hospital closures during the 1960's and 1970's, have sought to develop humane, health-promoting alternatives to long term hospital care for severely mentally ill persons in community settings. Case management services have emerged as a widely preferred alternative to fragmented outpatient care. In this approach, a specialist takes responsibility for facilitating access to and coordinating delivery of the full range of services needed by people with severe mental illness. General, or broker model, case management has been used for a variety of purposes ranging from cost cutting to improving clinical outcomes, and has only limited research support for its effectiveness. **Assertive community treatment (ACT)**, a model of integrated, intensive, and comprehensive services provided by a team of skilled clinical case managers in community settings, offers a more supportive approach for individuals with serious mental illness that has been carefully developed and evaluated.

ACT was first implemented as the Program of Assertive Community Treatment (PACT) in Madison Wisconsin over 25 years ago and evaluated in a series of experimental studies (Marx et al, 1973; Stein et al., 1975; Stein and Test, 1980a, 1980b; Weisbrod et al., 1980). ACT clinicians meet their clients in the community and provide comprehensive services, including social support, skills training, and medical care, wherever and whenever they are most needed (Allness and Knoedler, 2003; Stein and Santos, 1998). A team of up to 15 case managers provides an individualized care system in the community, replacing the custodial functions of an institution with personal support and therapeutic skills training in natural settings.¹

¹ A typical PACT team is staffed with a multi-disciplinary group of 10-15 clinicians who are configured to provide a comprehensive array of clinical and rehabilitation services every day (including evenings, weekends, holidays) and ensure 24 hour per day access for needed crisis intervention (Allness and Knoedler, 2003). A typical ACT team has 5-8 clinicians who, by necessity, provide less comprehensive services for fewer hours per week and rely on emergency/admitting staff or others to consult them about off-hour crises.

ACT Replication and Research

In the early 1980's, the success of the Madison PACT studies began to influence public policy. Wisconsin shifted inpatient treatment funds toward community-based services and Michigan funded Harbinger, the first replication of the PACT experiment (Mowbray et al., 1997; Mulder, 1985). By 1987, ACT principles had been adapted in demonstrations by numerous municipal and state mental health care systems, including Chicago, Philadelphia, Ohio, and New York (Test, 1992; Olfson, 1990; Burns and Santos, 1995; Deci et al., 1995). Replications varied with respect to the breadth and intensity of services, the accessibility and training of staff, and their effectiveness (Olfson, 1990; Stein, 1990; Deci et al., 1995; Essock and Kontos, 1995). Over the next ten years, at least 14 states developed ACT initiatives (Allness et al., 1997; Meisler, 1997). Rhode Island, Delaware and Texas established ACT as a standard "best practice" and required state-funded providers of services for the seriously mentally ill to develop ACT team services for their most troubled clients. In 1998, the Schizophrenia Patient Outcomes Research Team (PORT) highlighted ACT's effectiveness and relatively limited dissemination in its findings (Lehman et al., 1998). A year later, the National Alliance for the Mentally Ill (NAMI) made state funding for ACT services a central element of its anti-stigma advocacy campaign (NAMI, 1999). By 2004, most states reported the presence of an ACT team or active legislative/lobbying effort, with some (e.g., Florida, Illinois, Indiana, New Jersey, Virginia) funding multi-site state ACT initiatives (NAMI, 2004). Outside the United States, ACT has been adopted in Canada, Europe and around the world (Burns et al., 2001). Recent comparison of VA and non-VA treatments for schizophrenia found that VA clients were less likely to receive case management services (Rosenheck et al., 2001).

Experimental studies published over 20 years have reported that concentrating treatment resources in community-based ACT teams or intensive case management programs can result in improved clinical status of severely mentally ill patients at no additional cost (Bond et al., 1989; Hoult et al., 1984; Mulder, 1985; Stein and Test, 1980; Wasylenki et al., 1985; Weisbrod, Stein and Test, 1980). Other studies, however, have found case management to be associated with no clinical change and/or increased service utilization and cost (Bond et al., 1991; Curtis et al., 1992; Drake et al., 1998; Essock et al., 1998; Franklin et al., 1987; McFarlane et al., 1992). Literature reviews have concluded that intensive community treatment frequently reduces hospital use but does not always achieve net cost-savings or clinical improvement (Burns and Santos, 1995; Mueser, 1998; Olfson, 1992; Scott and Dixon, 1995). Most recent reviews have identified assertive community treatment as a clinically effective "evidence-based practice" when implemented correctly which can be cost-effective for clients who are high users of inpatient services (Phillips et al., 2001). A Cochrane Review concluded that ACT clients were more likely to stay in treatment and out of the hospital, to live more independently, and to be more satisfied with care than clients who received standard community or case management services (Marshall and Lockwood, 2002).

VA Demonstration: MHI, IPCC

VA initiated a demonstration program of intensive case management teams based on ACT principles at ten northeastern VA medical centers in 1987. Originally a regional demonstration (the Region 1 Mental Health Initiatives or MHI), VA's adaptation of assertive community treatment became known as Intensive Psychiatric Community Care (IPCC). A rigorous experimental study of this effort demonstrated the cost-effectiveness of this approach in VA (Rosenheck et al., 1995;

Rosenheck and Neale, 1998a). IPCC, while developed for the most troubled, high hospital users, was based on flexible operation guidelines that may be applied, with modifications, to other patient populations. Studies have shown that effective program performance requires adherence to the treatment model supported by training and performance monitoring (Rosenheck and Neale, 2001).

MHICM (formerly IPCC) Program Objectives and Principles

MHICM services are delivered by integrated, multidisciplinary teams and based on the Substance Abuse Mental Health Services Administration (SAMHSA) ACT standards. MHICM teams seek to deliver high quality services that:

- provide intensive, flexible community support;
- improve health status (reduce psychiatric symptoms & substance abuse);
- reduce psychiatric inpatient hospital use and dependency;
- improve community adjustment, functioning, and quality of life;
- enhance satisfaction with services; and
- reduce treatment costs.

To accomplish these objectives, MHICM teams adhere to four core treatment elements, most recently outlined in VHA Directive 2000-034:

- Intensity of Contact. High intensity of care primarily through home and community visits, with low caseloads (seven to fifteen veterans per clinician), allowing rapid attention to crisis and development of community living skills to prevent crisis in this exceptionally vulnerable population.
- Flexibility and Community Orientation. Flexibility and community orientation with most services provided in community settings and involving integration with natural support systems whenever possible (e.g., family members, landlords, employer).
- Rehabilitation Focus. Focus on rehabilitation through practical problem solving, crisis resolution, adaptive skill building, and transition to self-care and independent living where possible.
- Continuity and Responsibility. Identification of the team as a “fixed point of clinical responsibility” providing continuity of care for each veteran, wherever the veteran happens to be, for at least one year, with subsequent care subject to review of continuing need for intensive services.

Demonstration Findings

Analysis of data from the original multi-site MHI demonstration project yielded evidence that assertive community treatment principles could be adapted successfully within the VA healthcare system, that community-based treatment approaches could be effective in reducing hospital use and costs and improving clinical status, and that positive outcomes could be sustained or enhanced over extended time periods. Two-year demonstration findings (Rosenheck and Neale, 1998a) confirmed previous experimental research by showing significant reductions in hospital use and costs, and improvements in psychiatric status and social functioning, for veterans receiving IPCC services (Burns and Santos, 1995; Olfson, 1989; Scott and Dixon, 1995). Overall, average health care costs were \$4,860 (13%) less per patient per year for those treated in IPCC. The demonstration also illustrated the value of program monitoring that addresses facility and client characteristics, administrative mission and support, and model fidelity, all of which can substantially influence program development and impact (Rosenheck and Neale, 1998b; 2001).

Program Performance Monitoring

The resource intensity of IPCC services and the program's novelty for VA have warranted collection of data on client status, service delivery and utilization, and clinical and cost outcomes, through a national monitoring and evaluation system developed and managed by VA's Northeast Program Evaluation Center (NEPEC). Integration and feedback of national data have reinforced program accountability and maintained performance standards that have been shown in the scientific literature to be essential to program effectiveness.

The 1997 IPCC Report: 1) reviewed findings from a two-year experimental design evaluation of IPCC in VA; 2) presented extended follow-up data addressing long-term clinical and cost impact on a subset of patients whose progress was followed for up to five years; 3) described a novel training and performance monitoring program developed at the Northeast Program Evaluation Center (NEPEC) for dissemination of this model; and 4) summarized initial performance data from the program's national dissemination through March 31, 1997 (Rosenheck et al., 1997). Successive reports summarized program developments and performance data for veterans treated in Fiscal years 1998 through 2001 (Neale et al., 1999-2002). The present (eighth) report summarizes performance monitors and outliers for 4,761 veterans treated by 71 teams during FY 2004.

MHICM Directive and Network Implementation Plans

On October 2, 2000, VHA Directive 2000-034 (enclosed as **Appendix A**) described a new initiative to establish **Mental Health Intensive Case Management (MHICM)** teams throughout VHA, based on the established evidence-based practice of Assertive Community Treatment (ACT) (Phillips et al, 2001). IPCC, ACT, and other intensive case management services that met standards of service intensity and access were renamed as **MHICM**. The Directive defined the target population, standards and monitoring procedures for MHICM services. Shortly thereafter, VHA headquarters initiated a process through which each VISN would submit a detailed plan evaluating the need for MHICM in their network and describing specific steps to implement appropriate services. This initiative was the result of recommendations made by the Under Secretary for Health's Special Committee on the Treatment of Severely Mentally Ill Veterans (known as the SMI Special

Committee) to assure appropriate community care would be available for veterans in the face of substantially reduced inpatient capacity. When many of the initial network plans lacked sufficient detail, the request was reissued with additional guidance and specific response templates, with responses due at the end of September 2001.

Team Development

In 1997, VA facilities and Veterans Integrated Service Networks (VISN) began to express interest in implementing MHICM teams for veterans with serious mental illness or co-occurring mental illness and substance abuse disorders. Where feasible, NEPEC staff provided assistance in the form of information, material, linkage and technical support for sites with various levels of commitment to implementation of the model. To assist local leaders with planning and decision-making about community-based intensive case management services, NEPEC developed an Implementation Planning Packet in 1999. The packet contained descriptive materials and literature about MHICM, a brief bibliography, an outline of minimum program standards and expectations, and implementation/fidelity checklists addressing essential elements of MHICM and assertive community treatment. It is useful for planning a new MHICM team or comparing the structure of an existing case management team to the model. An updated version of this material, included as **Appendix B** in the MHICM report, is available with MHICM monitoring forms at NEPEC web pages via the VA intranet (<http://vawww.nepec.mentalhealth.med.va.gov>) and public internet (<http://www.nepec.org>).

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Chapter Two: National Assessment of MHICM Program Performance

VA Implementation of IPCC/MHICM

In 1993, responding to Congressional hearings and requests to enhance the priority of care for seriously mentally ill veterans within VA, the Director of Mental Health and Behavioral Sciences Service (Paul Errera, M.D.) submitted a “National Initiative for Seriously Mentally Ill Veterans” that featured the dissemination of Intensive Psychiatric Community Care (IPCC) programs. The VA National Planning Board approved the plan and Acting Under Secretary for Health agreed to provide \$1.5 million in FY 1994 and \$10 million in FY 1995 to establish new IPCC programs. The initial plan included additional funds for FY 1996 and FY 1997. VA Medical Centers and freestanding Outpatient Clinics were eligible to apply for IPCC funds, involving several levels of review.

Between 1993 and 1995, IPCC teams were implemented at 30 additional sites around the country using national funds, with one quarter of available resources allocated to each of the four existing regions. On the basis of detailed implementation and outcome data from the original MHI demonstration, a standard resource package was designed to support operation of IPCC teams. This package consisted of \$325,000 for 6.25 FTE; \$15,000 in All Other funds; and \$30,000 (10% of personnel) for medical center administrative costs, for a total of \$370,000 recurring. Seventeen sites were awarded the standard package and six sites were funded at lower levels (3.5 FTE; \$200,000 PS; \$15,000 AO; \$20,000 OH) due to lower number of eligible veterans or rural location.

In support of the national dissemination, teams at Brockton, Canandaigua, Montrose and West Haven each received 1.0 FTE to allow experienced staff to act as mentor-monitors for 6-8 new teams. Over a two-year period, mentor teams participated in various planning and training activities that included: a 2-day planning meeting; weekly conference calls; four orientation and training sessions with clusters of teams; site visits; and ongoing formal and informal communication via mail, e-mail, fax, and telephone. Staff from each new program site attended a 1-day orientation and training session with NEPEC staff, mentors and other programs, then accompanied mentor staff to their home facility for several days of direct observation and training. Calls were held weekly or biweekly for 6-12 months and then tapered depending upon team status. All new teams maintained formal contact with their mentors for at least one year after orientation and training.

In addition to regular contacts with new program sites, mentor-monitors reviewed each team’s progress via planning conference calls with NEPEC staff and other mentor-monitors (weekly: July 1994 to June 1996; quarterly: July 1996 to September 1997). Mentors also completed implementation checklists at six months and one year, reviewing with each team details of its configuration and operation. Finally, staff from each mentor team conducted at least one site visit of a FY 1994 program after nine to twelve months of operation. Site visits enabled mentors to observe the team when it was fully operational and to help the team resolve implementation difficulties.

Recent Implementation

In 1997, as VHA decentralized resource management, individual facilities and Veterans Integrated Service Networks (VISNs) began to request NEPEC consultation, training and technical assistance to implement MHICM teams. In subsequent years, teams were started with local resources in Detroit (MI), Central Iowa, Milwaukee (WI), St. Cloud (MN), Lyons (NJ) and the Rocky Mountain Network (VISN 19), and with network resources in VA Healthcare System of Ohio (VISN 10) and the South Central VA Healthcare Network (VISN 16). Many other sites requested information and consultation, and some facilities implemented case management teams that varied in structure and intensity of services without NEPEC assistance. VHA Directive 2000-034 prompted additional requests for consultation and training, and a network planning process described in Chapter One. To meet the training needs of new teams, NEPEC staff routinely request that network leaders provide support for team participation in face-to-face orientation and training, mentoring by a successful team and attendance at annual meetings of the Assertive Community Treatment Association (ACTA) or the United States Psychiatric Rehabilitation Association (USPRA, formerly IAPSRs),

Monitoring of the Bronx team was discontinued in 2000 after consultation revealed the program no longer operated within MHICM standards. Staff were reassigned to more traditional clinical and case management services. Mountain Home, Salisbury and Spokane teams merged with other programs, substantially impacting staff resources, caseloads, program fidelity and outcomes. More recent efforts to rejuvenate clinical operations at Salisbury have been successful.

MHICM National Program Monitoring

National monitoring of MHICM program performance, specified in VHA Directive 2000-034, relies on: client interviews, clinician and team progress reports, and centralized VA databases. Sources of data include: (1) Monthly FTE / Caseload reports monitoring program productivity, workload, staff turnover, and admissions; (2) Structured clinical interviews with each veteran at entry (Initial Data Form-IDF) and (semi-) annually thereafter (Follow-up Data Form-FDF) addressing client characteristics, clinical status, functioning, and service use; (3) (Semi-)Annual clinical progress reports of MHICM services and outcomes, completed by the veteran's primary case manager; (4) VA automated inpatient and outpatient service use data; (5) Fidelity assessments of team conformity with MHICM and ACT program guidelines; and (6) Staffing and budget summaries completed for an annual site progress report. Evaluation forms have been abbreviated to reduce paperwork demands.

MHICM program evaluation and monitoring variables target four domains following the classic formulation of Donabedian (1980): 1) **Program structure**: utilization and configuration of allocated resources, and caseload levels; 2) **Client characteristics**: socio-demographic, disability level, and clinical status at entry; 3) **Program Process**: pattern of service delivery, therapeutic activities and alliance, and readmissions; and 4) **Outcomes**: client use of hospital services, symptoms, functioning, quality of life, and satisfaction with services.

The following section of the report presents data on each monitoring domain, from client interviews, clinician progress reports, and automated databases, for veterans with follow-up data between October 1, 2003 and September 30, 2004. **Table 2-1** lists 47 current MHICM program monitors, indicating for each its relevant domain and program objective, the table in which its data

are presented in this report, and whether it is a “critical” program monitor (see below). Monitoring data are summarized in 33 tables and 6 figures. **Appendix D** summarizes the source and creation of all variables included in performance monitoring tables for this report. All MHICM teams participate in national performance monitoring, including the use of specific DSS identifiers (552, 546, 567) for clinical workload. Programs providing less intensive case management services exclusively are not monitored but workload is reported under DSS identifier 564. In FY 2001, VHA revised the Veterans Equitable Resource Allocation (VERA) reimbursement structure by adding veterans with 41 or more MHICM (552) visits in a year to those for whom networks receive higher reimbursement. For FY 2004, the potential reimbursement difference amounted to \$32,709 per veteran.

Monitoring Team Performance

Premises on Which the Monitoring System is Based. MHICM is still a relatively new clinical activity in VA, requiring considerable freedom for clinical innovation. Monitoring efforts are based on the assumption that rigid regulations or performance standards might stifle the creative evolution of the model and fail to account for local variation. At the same time, since VA and non-VA studies show that poor implementation is associated with low cost-effectiveness (Rosenheck and Neale, 1998b; Mueser et al., 1998; Phillips et al., 2001), it is important to monitor the program as completely and objectively as possible, identifying performance standards as suggested by research. Through this monitoring system we have sought to assemble a body of data that can guide national and network program developers and front line clinicians as they implement MHICM teams in the years ahead.

Critical Monitors: Statistical Norms vs. Practice Standards. Although a complete set of practice standards has not been established for this program, monitoring data allow more than a description of individual site performance and statistical norms have been computed for selected critical monitors. The distinction between statistical norms and formal practice standards is an important one. Practice standards are established by a consensus of professionals as directive guidelines for appropriate clinical practice. They codify how health care should be conducted. Statistical norms, in contrast, reflect how health care is practiced on average without specifying exactly what is or is not acceptable practice. Although some practice standards have been established for the MHICM program through VHA Directive 2000-034, many aspects of the program have yet to be quantitatively standardized. Even in these areas, however, practice variation within the MHICM program can be measured and statistical outliers can be identified. Identification of statistical outliers must not be confused with identification of practice standard violations. Statistical outliers are worthy of attention as extremes on a continuum but, without exploring specific circumstances, one cannot draw conclusions about their exact meaning for program performance at a particular site.

FY 2004 Critical Monitors. Nineteen of forty-seven current MHICM measures identified in Table 2-1 were selected as critical monitors that assess aspects of the program of special importance to fulfilling its mission.² Most of these monitors have clear directionality (i.e. extremely large or small values suggesting a departure from program values and goals). Again, performance monitors should not be considered in isolation as absolute indicators of the quality of care delivered at any site.

²Two monitors from the 1997 Report were dropped from national monitoring when the Readmission Review Form was made optional as part of paperwork reduction effective January 1, 1998. Client symptom and functioning monitors (each comprised of two measures) were separated, with no net change in monitors.

In most cases they can be used to properly identify statistical outliers, the importance of which must be determined by follow-up discussions or visits with the sites.

Identification of Statistical Outlier Sites. For each monitor, site data are presented in tabular form. At the bottom of a column, sums and averages across all veterans (ALL SITES) are presented, along with the mean and standard deviation for teams included in the table (SITE). In the original report, sites were identified as outliers on a variable if the site value was more than one standard deviation from the mean. For subsequent reports, outliers have been identified by a more complex statistical procedure involving **risk adjustment** for differences in baseline characteristics of veterans across sites as well as differences in sample size. First, simple change scores are created for each variable by subtracting Pre- (entry or baseline) values from Post- (latest follow-up) values, and computing site means. Second, baseline covariates are standardized by subtracting the overall mean from individual values and computing transformed means. Third, analyses of covariance are run for each outcome, using 13 baseline covariates and 2 time-in-program variables. Least-squares means adjusted for covariates are computed for each site and t-tests are run comparing the adjusted means from each site with the median site value. Sites that differ statistically from the median site (p value <0.05) in the **undesired** direction are identified in Tables 2-6 to 2-25 with a shaded value. Sites that differ significantly from the median in the **desired** direction are identified with a bold underlined value. The performance of outlier sites is significantly different from the median site after adjusting for differences in veteran characteristics at entry and duration of program involvement.

It is important to note that outliers on critical monitors are being identified on a purely statistical basis. This is a more rigorous and conservative approach that, unlike previous use of standard deviations to identify outliers, accounts for site and other differences at baseline, baseline values of the variable in question, and length of time veterans are in the program. For variables where all site values are close together, no outlier may be identified. For variables where site values are skewed, outliers may be identified in one direction but not the other. For variables where site values are normally distributed, a balanced number of outliers may occur in both directions.

Minimum Program Standards

VHA Directive 2000-034 establishes procedural guidelines for MHICM teams that have been operationalized in eight **minimum program standards**. These complement the critical performance monitors. Minimum standards and threshold values include:

- Percent of veterans with psychotic diagnosis at entry (50% or more)
- Percent of veterans with 30 or more psychiatric inpatient days in year before entry (50% or more)
- Mean adjusted face-to-face contacts per week/veteran (1.0 or more)
- Ratio of veterans to clinical FTEE (mean caseload) (7:1 to 15:1)
- Percent of veterans for whom at least 60% of contacts occur in community setting (50% or more)
- Percent of veterans receiving psychiatric rehabilitation or skills training services (25% or more)
- Percent of veterans discharged from MHICM program (< 20%)
- Number of clinical service providers on the team (4.0+ FTEE).

Summary of Outliers. **Table 2-27** summarizes the number of Critical Monitor outlier values identified for each site in four major evaluation domains: program structure, client characteristics, program process and outcome. Critical Monitor outlier values are presented separately by domain in **Tables 2-28 to 2-31**. Outliers for Minimum Program Standards are presented in **Table 2-32**. Negative outlier values are outlined in summary tables. Data were made available to sites for review and discussed on national conference calls. NEPEC program assistants confer with individual sites about specific outlier variables as program evaluation and planning continue during the year.

Team Outlier Review. Prior to publication of this report, MHICM teams were asked to review draft tables and comment on critical monitors where their team value was identified as an outlier in the undesired direction. To facilitate review and comment, draft tables were posted on an intranet web site for direct access by MHICM teams. Outlier review responses are summarized in **Table 2-33**. The outlier review request and form are included in **Appendix C**.

Program Structure

MHICM Sites, Resources, and Expenditures

Seventy-one of seventy-eight MHICM teams that were in operation during FY 2004 and provided follow-up data on ten or more clients are listed in **Table 2-2**, characterized by site type and year of program start-up. Two established teams (Fort Harrison, Mountain Home) and five developing teams (Baltimore, Columbia, Danville, Philadelphia, Washington, DC) had insufficient data to be included in this report. The original MHI demonstration programs began in 1987. Teams at Chicago (West Side), Miami and Portland, initiated in 1992, were funded primarily by reallocating resources from three original IPCC teams that were discontinued for incomplete implementation of the program model. Dissemination sites were funded in 1994 and 1995, as part of VA's National Initiative for Veterans with Serious Mental Illness. Four orientation and training sessions were conducted with thirty dissemination sites between August 1994 and July 1995. Subsequent teams (1998 to present) were developed from local or network initiatives.

With decentralization of VA resource management to Veterans Integrated Service Networks (VISNs) in 1996, individual facilities and networks became the locus for funding and implementing new IPCC teams. The first locally funded and nationally monitored IPCC team was initiated by the John D. Dingle VA Medical Center in Detroit, Michigan in 1997. Additional teams were started with network resources by: Healthcare System of Ohio (VISN 10) (1998, 2001), South Central Healthcare Network (VISN 16) (2001), Mid-Atlantic Healthcare Network (VISN 6) (2002), Stars and Stripes Healthcare Network (VISN 4) (2003) and with local resources by: VA Midwest Healthcare Network (VISN 23) (1999, 2002), Rocky Mountain Network (VISN 19) (2000), Capitol Health Care Network (VISN 5) (2003), VA Palo Alto Healthcare System (2002), St. Louis VA Medical Center, VA Southwest Health Care Network (VISN 18) and VA Heart of Texas Health Care Network (VISN 17) (2003) and Pacific Healthcare Network (VISN 22) (2004).

In each case, the MHICM Project Director and NEPEC evaluation staff collaborated with an established MHICM ("mentor-monitor") team to provide orientation, training, and ongoing technical assistance for new team members during start-up. Mentors were assigned to observe team operation and service delivery, and consult on clinical or administrative questions. Regular conference calls

were held with members of new teams to support network communication about MHICM and community service needs of veterans with serious mental illness.

VHA resource allocation systems in recent years have diminished historical differences between General Medicine and Surgery (GM&S) and former Neuro-Psychiatry (NP) facilities. To illustrate the influence of facility type on the client population and therapeutic emphasis of individual MHICM teams, we continue to compare client characteristics for the two facility types. As of 2004, the proportion of teams (25 of 71; 35%) and total veterans (1,982 of 4,176; 46%) located at NP sites has grown somewhat since the original study (30% of sites and 40% of veterans), reflecting greater numbers of veterans who meet MHICM criteria at NP sites.

Initial resource allocations to current MHICM sites are enumerated in **Table 2-3**. Resources for early teams are presented in 1988 and 1993 dollars, respectively, and exclude funds for local administrative support as none were provided until 1994. Original programs involved more diverse treatment models and staffing configurations. Initial site resources reported in annual progress reports bring the total funds for MHICM programs in the most recent fiscal year (2004) to more than \$24M, with 90% of funds going to cover personnel costs, and the remainder going to All Other expenses.³ Allocation data have become less meaningful with decentralization of healthcare funding.

MHICM program expenditures for FY 2004, derived from site-generated annual progress reports, are summarized in **Table 2-4**. These data appear to accurately reflect expenditures for program staffing and operation at most sites during that period, although it was not possible to verify program funds merged with other services in mental health service line consolidations. Program expenditures for the 71 MHICM teams included in this report totaled \$33.8M during FY 2004, with \$31.9M (94%) expended as Personal Service funds for 415.2 FTEE. Cost data from MHICM teams not included in this report (they had fewer than 10 veterans with complete follow-up data) brought the national expenditure total to almost \$36M. Average costs were \$476,413 per team, \$76,890 per filled FTE (salary plus benefits), and \$7,105 per veteran client. Unit cost data, sensitive to the proportion of new teams, are provided in Table 2-26.

Table 2-5 presents the assignment and utilization of staff resources through FY 2004. More than half (40 of 71; 56%) of teams included in this report had 4.0 or more clinical FTE providing clinical services in the community as mandated by VHA Directive 2000-034, an improvement of 22% (24 of 52) over FY 2002. Of 31 teams below the clinical FTE standard, 11 (35%) lacked 0.5 FTE, the portion of team leader time accounted for team administration. Community standards for assertive community treatment define the team leader position as equal parts clinical and administrative, to assure the leader time for direct experience with community-based service delivery and participation in administration, supervision, liaison, and personnel management on behalf of the team.

Although most MHICM positions (92%) were filled, 22 teams (31%) had vacancies of more than 6 months as of September 30, 2004, a 33% decrease from FY 2002 (29 of 63, 46%). In addition, MHICM FTE from 11 teams (15%) had been detailed elsewhere without replacement for more than six months, a 50% decrease from FY 2002 (19 of 63, 30%). Some personnel gaps were enduring,

³ In recognition of administrative costs associated with support for an IPCC team, each dissemination site received an increment of 10%, based on Personal Service dollars, for unmonitored administrative use.

with vacancies at fifteen of twenty-eight teams (54%) in FY 2003, nine of eighteen teams (50%) in FY 2002, and six of sixteen teams 38% in FY 2001, still unfilled at the end of FY 2004. Similarly, FTEE detailed away from the MHICM program at nine of nineteen teams (47%) in FY 2003, six of eleven teams (54%) in FY 2002, and six of twelve teams (50%) in FY 2001, were still detailed away at the end of FY 2004. In sum, many MHICM teams struggle to retain clinical resources even though the standard mandated by VHA Directive 2000-034 is well below that for assertive community treatment teams in other systems.

On the positive side, some MHICM teams benefited from local and network contributions of additional staff resources. Four of five staff in filled MHICM positions (338 of 415 FTEE or 81%) provided direct clinical services, primarily in community settings. This figure included 0.5 FTEE for team leaders, who were expected to provide a reduced level of community services, but excluded psychiatrists (about 15 FTE) (who generally devoted less than one day per week to MHICM veterans and rarely provided services in the community) and administrative-clerical support staff.

Caseload Levels

Clinical staffing levels and caseloads attained by each program for FY 2004 are shown in **Table 2-6**. Medical Support refers to the assignment of psychiatrists and nurses as members of the multidisciplinary team. Most teams maintained the active involvement of an assigned psychiatrist (69%) or nurse (94%) on the team. Clinical staffing levels varied considerably across sites, from fewer than 3.0 FTE at Columbus, Miami, St. Louis, Salisbury, San Diego, Sheridan and Togus to more than 9.0 FTE at Bedford, Canandaigua and Cleveland (including locally contributed resources). Fifty-nine teams (83%) maintained caseloads within the range specified by VHA Directive 2000-034 (7 to 15 clients per clinical FTE), with ten teams (14%) **above** the specified maximum (15:1) as of September 30, 2004. The latter is a modest (12%) improvement over FY 2003 (10 of 63, 16%). Several teams maintained lower caseload levels or waiting lists to preserve the intensity of their services in the face of persistently unfilled clinical positions.

Client Characteristics

Demographics and Entry Criteria

Socio-demographic characteristics for 4,761 MHICM veterans are presented in **Table 2-7**, for all sites combined (Overall) and by Site Type (GM&S, NP). Current data are comparable to original MHI study values (Rosenheck and Neale, 1998a; Rosenheck et al., 1995), with more Hispanic and African-American veterans, and fewer combat veterans, in the current group. One in five veterans (20%) reported exposure to combat. Few veterans (12.5%) reported paid employment in the three years preceding program entry. Site Type differences are less pronounced than those reported in the original multi-site study, though veterans from former Neuro-Psychiatric facilities are slightly older, more likely to be Caucasian, and less likely to have been married.

Tables 2-8 and 2-9 present Overall, Site Type, and Site data characterizing MHICM veterans at entry. Teams varied in their implementation of MHICM entry criteria. FY 2004 national MHICM program standards called for each veteran to meet the following criteria: 1) primary psychiatric diagnosis, especially a psychotic disorder; and 2) 30 or more days OR 3 or more stays of VA

psychiatric inpatient hospitalization during the year preceding program entry. These criteria were selected and monitored to ensure that resource-intensive MHICM programs targeted veterans with the greatest need for intensive support and the greatest opportunity for VA cost savings. As in the original demonstration, the current overall population of MHICM veterans met target criteria defining veterans with serious mental illness who are high users of VA psychiatric resources. All program participants had a primary DSM-IV psychiatric diagnosis and 75% had been hospitalized for a month or more in the year preceding entry. One in five veterans (21%) was diagnosed with a co-morbid substance abuse disorder. System-wide decline in length of stay has reduced the proportion of veterans meeting utilization criteria. As a result, current MHICM veterans spent an average of 70 days (± 46 days) in the hospital in the year prior to entering the program, compared with 135 days {a -48% difference} for the 1997 Report (Rosenheck et al., 1997) and 144 days {-51%} for the original demonstration (Rosenheck and Neale, 1998a). Since 1997, the percentage of veterans entering the program directly from a VA psychiatric inpatient unit has fallen sharply, from 98% to 36%, and the proportion of veterans meeting the 30-day hospital use criterion has declined, from 91% to 75%.

Disability Status

Disability income data, presented by site in Table 2-9, reveal extensive VA and Social Security support for psychiatric disabilities among MHICM veterans at entry. More than half of MHICM veterans (N=2,248 of 4,057; 55.4%) reported receipt of VA compensation for a service-connected disability. Of these, 1,484 (74.2%) veterans were service-connected exclusively for a psychiatric disorder, 305 (13.6%) exclusively for a physical disability, and 275 (12.2%) for both. One in five (N=717, 18.5%) veterans reported receiving a non-service-connected disability pension. Many veterans reported receiving Social Security income (SSI: 15.1%; SSDI: 49.7%). Virtually all MHICM veterans (N=3,816; 94.1%) reported receiving some combination of VA and/or Social Security funds, and almost half (46.8.2%) said a representative payee managed their finances. Although the percentage of MHICM veterans who received VA compensation for service-connected disorders ranged from 36% to 90% across sites, the proportion of veterans receiving some form of disability support was consistently high, between 80% and 100%.

Program Adherence to Entry Criteria

Overall, MHICM teams demonstrated substantial adherence to entry criteria, presented in **Table 2-10**, despite facility differences on specific variables. Most veterans ($75.1\% \pm 20.5\%$ {standard deviation}) met the 30-day criterion for psychiatric hospital use in the year preceding entry. VHA service use data indicate that 83% of MHICM veterans also had 3 or more stays in the previous year. The vast majority of MHICM clients ($90.2\% \pm 7.5\%$) had a psychotic diagnosis (schizophrenia, schizo-affective disorder, other psychosis, bipolar disorder) at entry. One in five veterans ($20.9\% \pm 12.9\%$) had a secondary diagnosis of alcohol or drug abuse. Teams at Albany, Bedford, St. Cloud, Salem, Sheridan and Tomah greatly exceeded the national level by targeting veterans with co-occurring diagnoses of mental illness and substance abuse. Two in five MHICM veterans ($43.6\% \pm 16.9\%$) had been hospitalized for two or more years but there was substantial site variation (range: 17.9% to 84.7%). Characteristic of typical onset of psychotic disorder in early adulthood, veterans reported histories of illness spanning more than two decades since their first hospitalization (mean = 23.1 ± 3.1 years; range: 15.5 to 31.9 years).

Measures of clinical status at program entry, shown in **Table 2-11**, indicate levels of client symptoms and functional impairment commensurate with extensive hospitalization and long-term mental illness. More than half of MHICM veterans ($51.5\% \pm 11.0\%$) reported low-level instrumental functioning on at least one activity of daily life (managing household chores, shopping, finances, medications). Despite accommodations to inpatient life by many veterans prior to entry, clinician ratings of global functioning at program entry were low (GAF mean: 39.9 ± 5.1) and interviewer ratings of observed symptoms were relatively high (BPRS mean: 40.6 ± 6.5), reflecting moderate psychiatric impairment. (Note: BPRS ratings were re-scored on a 1-Not Present to 7-Extremely Severe scale to conform with scoring guidelines and current reporting conventions). One in three MHICM clients ($35.9\% \pm 24.1\%$) entered the program directly from an inpatient unit in FY 2004 and veterans were more likely to have been discharged or referred by an outpatient service. This extended a clear trend from the first report (when 98% of clients entered directly from the hospital) reflecting dramatic changes in psychiatric lengths of stay within VA since 1997.

Program Process

Program Tenure

MHICM principles emphasize continuity, frequency, intensity, and community-based services for veterans with serious and persistent mental illnesses who have not responded well to traditional modes of treatment. With respect to continuity, MHICM programs are expected to serve as a fixed point of clinical responsibility for their veterans, offering services for at least one year and providing services for as long as clinically necessary. Continuity data in **Table 2-12** indicate that MHICM programs continue to meet this expectation. A modest number ($N=749$, 15.7%) of MHICM clients ($N=4,761$) were discharged during the twelve-month report period. One hundred and thirty-seven additional veterans (2.9%) were formally transitioned to less intensive services by MHICM team staff per criteria defined by VHA Directive 2000-034. Of the 749 clients who were discharged, 187 (24.7%) veterans left the area and 91 (12.0%) veterans died (83 from natural causes, 7 from self-inflicted injuries). The rest of the discharged veterans asked to leave the program because they felt they no longer needed the services ($N=90$, 19.6%), formally graduated from the program ($N=18$, 4.0%), or for unspecified reasons ($N=144$, 31.2%). On average, veterans in the report (those with follow-up data during Fiscal Year 2004) had participated in the program for more than three years (mean= $1,301 \pm 615$ days) at the time of the latest follow-up interview.

Service Delivery and Alliance

Table 2-13 presents service delivery data provided by MHICM case managers through structured semi-annual case summaries. These data indicate MHICM has been implemented according to principles that have been shown to result in positive outcome (Rosenheck and Neale, 1998a; McGrew et al., 1994). With respect to frequency of contact, 88.2% ($\pm 9.9\%$) of veterans were seen weekly or more and 52.8% ($\pm 17.4\%$) received telephone contacts on a weekly or more frequent basis. Regarding intensity of contact, 61.4% ($\pm 16.3\%$) of veterans were seen for more than an hour per week in the latest six-month period (after a mean of 3+ years in the program). Pertaining to location of contact, 89.3% ($\pm 9.5\%$) of veterans received more than 60% of their care in the community. FY 2004 contact levels are within a percentage point higher than FY 2003 values (Neale et al., 2004).

An important aspect of MHICM treatment involves the volume of direct, or face-to-face, contact between staff and clients, recorded as clinic stops in VA's centralized outpatient database, the National Patient Care Database (NPCD). MHICM teams record the bulk of their workload under DSS Identifiers #552 (MHICM Community Visit) and #546 (MHICM Telephone Contact). A clinic stop for MHICM group activities (#567), added in FY 2004, will be summarized in future reports. Overall, as illustrated in **Table 2-14**, each MHICM client had an average of 58 (± 21.4) face-to-face visits by MHICM staff in the twelve months preceding September 30, 2004, plus 3 (± 4.7) telephone contacts, for a cumulative national total of 279,350 visits. Adjusting visits to reflect the portion of the year that clients were enrolled in MHICM (mean = 83% \pm .07) at each site amounts to about 69 (± 25.0) face-to-face visits over twelve months or 1.33 visits per week, per veteran. Including telephone contacts, each veteran received about 73 total contacts, or 1.4 contacts per week, in FY 2004. Since each veteran can receive only one clinic stop per day for a given service, and veterans may have multiple contacts during the day, these data are likely to under-represent the actual level of MHICM contact. Overall, FY 2004 MHICM workload was virtually the same as in FY 2003 (1.35 visits / week) and beneath program expectations of 2-3 contacts per veteran per week. The proportion of teams (19 of 71; 26.7%) averaging less than one face-to-face contact per week (the negative outlier value) was virtually unchanged in FY 2004 after drops of 17% in FY 2003 and 32% in FY 2002.

Table 2-15 depicts the breadth of services provided by MHICM teams to program veterans during FY 2004. Most often, clients received supportive contact (97%), active monitoring (96%), psychotherapeutic interventions (83%), medication management (82%), and medical screening (75%). Less frequently, teams provided crisis intervention (68%), social or recreational activities (64%), housing support (52%) or rehabilitation services (49%). Substance abuse intervention (32%) was generally limited to veterans with specific needs related to dual diagnosis. Vocational support (21%) was the least used service with this severely disabled population. FY 2004 service levels increased slightly over FY 2003 values for vocational support (6%) but remained stable for other services.

Clinical case management models stress the importance of the therapeutic relationship between case manager and client, based on frequent and individualized contact, for improving clinical status (Harris and Bergman, 1993; Kanter, 1989). On the basis of earlier retrospective evidence linking therapeutic alliance with MHICM outcomes (Neale and Rosenheck, 1995), case manager-client alliance was monitored at all sites using seven-item versions of the Working Alliance Inventory modified to reflect case management work (Horvath and Greenberg, 1989). **Table 2-16** compares MHICM client perceptions of their current alliance with MHICM case managers at follow-up (Alliance mean: 39.8 \pm 3.7) to adjusted ratings of their perceived alliance with previous inpatient / outpatient treaters, reported at entry (Alliance mean: 36.2 \pm 2.2). Overall, client ratings of alliance were 10% higher for MHICM staff than for previous treaters, and veterans at 64 (90%) of 71 sites reported higher levels of alliance with MHICM staff.

ACT Model Fidelity

Each MHICM team completed a measure of program fidelity to prescribed elements of assertive community treatment, the Dartmouth Assertive Community Treatment Scale (DACTS; McGrew et al., 1994; Teague et al., 1998). The measure examines team conformity with ACT program criteria pertaining to human resources, organizational boundaries, service delivery, and

substance abuse treatment. Previous research has found that fidelity scores, particularly team factors, correlate strongly with reductions in hospital use (McGrew et al., 1994), and distinguish between effective and ineffective treatment teams (Teague et al., 1995). Results for MHICM programs, displayed in **Table 2-17**, show the teams performed well on three of the four domains [mean scores of 4.0 (human resources), 4.4 (organizational boundaries), and 3.9 (services)]. The fourth domain of the scale pertains to substance abuse treatment, which is not a primary emphasis of MHICM treatment, and results vary significantly by team (mean 2.9, range: 1.0-5.0). Although secondary substance abuse diagnoses are present in 20-25% of MHICM veterans at entry, most teams view a primary substance abuse diagnosis as an exclusion criterion. The overall MHICM DACTS score (mean = 4.0 \pm .3) approximates those for other successful public sector ACT teams (Teague et al., 1998), despite including some teams that have shifted MHICM staff to other models of care. More than half (39 of 71, 55%) of MHICM teams achieved a score of 4.0 or more on the ACT Fidelity scale for FY 2004. [Note: VA scores include 23 of 26 original DACTS items. As a result, VA averages may be compared with non-VA programs but VA total scores are lower.]

Distance and Travel Time

For annual Clinical Progress Reports on their work with MHICM veterans, teams estimated the distance and travel time between their office and each veteran's residence. Follow-up reports indicated that most MHICM clients lived within 20 miles (N=2459, 69.3%) and 30 minutes (N=2410, 68.6%) of team offices (see **Figures 2-1 and 2-2**). At the same time, sizeable numbers of veterans lived between 21 to 40 miles (N=728, 20.5%) or 30 to 60 minutes (N=938, 26.7%) away, and some more than 40 miles (N=361, 10.2%) or 1 hour (N=164, 4.7%) away. The data suggest that MHICM teams have substantially extended access to VA mental health services for veterans with serious mental illness through their outreach activities.

Clinical Outcomes

Reduction in VA Hospital Use

A primary objective of MHICM teams is to reduce veteran reliance on psychiatric inpatient services in favor of more adaptive and less costly treatment alternatives. As evident in **Table 2-18**, this objective was well met, with all teams showing pre- to post-entry reductions in mental health hospital days after six, twelve and eighteen months. Only two teams (Grand Junction, Milwaukee) showed any increase in hospital use after 24 months. On average, MHICM veterans (N=4,198) reduced their VA psychiatric hospital use from 42.5 days pre-entry to 12.2 days post-entry (mean reduction = -30.3 \pm 23.6 days) during their first six months in the program. Overall, hospital use reductions of similar magnitude (69-71%) were observed for periods of 12 months (**Table 2-18a**: N=3,723, -48 days), 18 months (**Table 2-18b**: N=3,285, -67 days), and 24 months (**Table 2-18c**: N=2,900, -88 days).⁴ About half of the teams (31 of 63; 49%) had average reductions of 30 or more days per client after one year. As in the original demonstration (Rosenheck and Neale, 1998a), NP

⁴ Paired t-tests revealed overall reductions in VA mental health hospital days to be statistically significant at 6 months (N=4,131, mean difference=-30.84, t=-39.29, p<0.0001), 12 months (N=3,683, mean difference=-48.79, t=-33.39, p<0.0001), 18 months (N=3,246, mean difference=-67.89, t=-30.24, p<0.0001), and 24 months (N=2,864, mean difference=-88.98, t=-28.36, p<0.0001).

teams continue to show greater reductions and cost savings relative to GM&S teams, although GM&S teams have been consistently effective in recent implementations. Hospital use reductions for teams at Northport, Hampton, Salem, Salisbury, Atlanta, Tuscaloosa, Northern Indiana and Tomah were diminished somewhat because some clients with few recent hospital days were “grandfathered” into MHICM from a pre-existing case management program.

One estimate of inpatient cost reductions associated with MHICM entry can be obtained by multiplying the mean reduction in hospital days by the national average hospital per diem rate (FY 2004 inpatient psychiatry per diem = \$1,011) (Greenberg and Rosenheck, 2005). This method yields estimated inpatient cost reductions, per client, of \$30,678 at 6 months, \$48,708 at 12 months, \$67,737 at 18 months, and \$88,685 at 24 months, unadjusted for inflation. Although some reduction in hospital use is certainly attributable to expected client improvements over time and course of illness and to system-wide reductions in hospital use, present data suggest substantial cost reductions for veterans with serious mental illness who receive MHICM services.

Improvement in Clinical Status

Consistent with the MHICM mission and objectives, monitored outcomes include improvements in health status, community functioning, and quality of life, as well as customer satisfaction. Outcome measures include ratings of:

- Symptoms by clinician: Brief Psychiatric Rating Scale {BPRS}, Overall and Gorham, 1962;
- Symptoms by client: Symptom Severity {GSI}, Derogatis and Spencer, 1982);
- Global functioning by clinician: Global Assessment of Functioning {GAF}, American Psychiatric Association, 1995, Endicott et al., 1976;
- Instrumental functioning by client: Instrumental Activities of Daily Living {IADL}, Fischer et al., 1996);
- Quality of life by client: Lehman Quality of Life Inventory {QOL}, Lehman, 1988); and
- Satisfaction with VA mental health {VAMHSAT} and MHICM services {MHICM SAT} by client.

For each outcome measure, scores at program entry were compared with scores for the latest 6-month follow-up period in the report window (October 1, 2003 to September 30, 2004). Individual scores were adjusted for fifteen covariates including client characteristics, baseline values, and time in program. Median time in MHICM was 36 months. Data are presented in Tables 2-19 to 2-25.

Case manager ratings of 18 observed symptoms (BPRS) for MHICM clients, summarized in **Table 2-19**, showed an overall reduction of 13.9% from entry (N=4,015, mean sum: 40.6±6.5) to follow-up (mean sum: 34.9±11.5). Observed symptoms decreased at 60 of 71 sites (85%). Client ratings of severity for 30 symptoms on a 4-point scale (GSI: 1-not at all to 4-a great deal) (Fischer et al., 1996), in **Table 2-20**, yielded a similar overall reduction of 13.0% from entry (N=3,878, mean: 1.78±0.20) to follow-up (mean: 1.55±0.31), with lower 6-month ratings at 62 of 71 sites (87%).⁵

⁵Paired t-tests yielded significant differences reflecting improvement in both observed (N=2,478, mean difference: -5.72, t=-17.34, p<0.0001) and reported symptoms (N=2,314, mean difference: -0.22, t=-16.65, p<0.0001).

Reduction in Violent and Suicidal Behavior

MHICM veterans were asked whether they had thought or talked about harming someone, threatened anyone, or actually harmed anyone during their last 30 days in the community. Clients were also asked if they had been arrested or spent a night in jail, for any reason, during the six months preceding the interview. Entry and follow-up responses are presented in **Figure 2-3**. At entry, one in five veterans (N=729, 18.6%) reported thoughts of violence, one in eight (N=520, 13.3%) talked about hurting someone, one in eleven (N=342, 8.7%) threatened someone, and one in thirty (N=131, 3.3%) committed a violent act. At follow-up, levels of violence were much lower across all categories, with 41% fewer veterans reporting violent thoughts (N=294, 11.0%), 53% fewer veterans reporting violent talk (N=165, 6.2%), 63% fewer violent threats (N=86, 3.2%) and 54% fewer violent actions (N=23, 0.9%). The number of veterans reporting arrest (pre: N=359, 9.0%; post: N=64, 2.3%) or jail (pre: N=246, 6.2%; post: 42, 1.5%) also declined, by 75%, at follow-up.

Using similar items, MHICM veterans were asked if they had thought or talked about harming or killing themselves, threatened or attempted suicide in their last 30 days in the community, and whether a suicide attempt had resulted in hospitalization for medical reasons (see **Figure 2-4**). Though one in four veterans (N=1,009, 25.7%) reported thinking about suicide prior to entry, and one in six (N=608, 15.4%) had talked about it, fewer veterans had threatened (N=327, 8.3%) or attempted (N=205, 5.2%) suicide. All veterans who attempted suicide were hospitalized for medical reasons. At follow-up, the number of veterans in all of these categories had declined substantially, with fewer reports of suicidal thought (N=271, 10.1%), talk (N=142, 5.3%), threat (N=47, 1.7%), or attempt (N=8, 0.3%). Over a one-year period, 5 (0.01%) of the 4,761 veterans targeted in this report died from a completed suicide attempt. Another 105 veterans (2.2%) died from natural or unknown causes.

Indices based on the items described above showed statistically significant reductions in both violence (N=2,374; mean difference: -0.21, $t=-10.06$, $p<0.0001$) and suicidality (N=2,376; mean difference: -0.39, $t=16.62$, $p<0.0001$) for MHICM veterans.

Global and Instrumental Functioning

Case manager ratings of client global functioning (GAF) are presented in **Table 2-21**. VHA adoption of the Global Assessment of Functioning as a national performance monitor for VA mental health in 1998 prompted many facilities to re-train staff in use of the measure, often resulting in a more conservative scoring range. As a result, follow-up GAF scores were lower at many sites (27 of 71 sites, 38%), particularly for established teams with earlier baseline data. Overall means were 3.9% higher at follow-up (mean: 40.9 ± 9.9) than at entry (N=3,453; mean: 39.9 ± 10.5), a statistically significant t-test difference (N=2,480; mean difference: 1.32, $t=6.24$, $p<0.0001$) that is comparable with the 3.5% increase after six months in the first MHICM report (Rosenheck et al., 1997).

Client ratings of performance frequency (1-almost never to 5-almost always) for twelve specific daily skills (IADL), presented in **Table 2-22**, improved slightly (+3.2%) from entry (N=3,450, mean sum: 44.5 ± 3.3) to follow-up (mean sum: 45.6 ± 5.1). Two out of three teams (46 of 71, 65%) showed some level of improvement at follow-up and the overall t-test difference was statistically significant (N=1,809; mean difference: 1.40, $t=5.94$, $p<0.0001$).

Enhanced Quality of Life and Independence

Client ratings on five life satisfaction items (QOL; Lehman, 1988) using a 7-point scale (1-terrible to 7-delighted), reported in **Table 2-23**, indicated improvement (10.0%) from entry (N=3,618, mean sum: 26.1 ± 1.3) to follow-up (mean sum: 29.0 ± 2.1). Clients from 69 of 71 teams (97%) reported higher quality of life after participation in MHICM.⁶

Veterans were asked to indicate the number of nights in their most recent month in the community that they had spent in any of five living situations: a) **independent** (alone or with spouse, family, or friend in apartment or house); b) **minimally restrictive** (supervised apartment, boarding home, adult foster care); c) **moderately restrictive** (halfway house, treatment program, acute psychiatric diversion facility, treatment lodge, domiciliary); d) **extremely restrictive** (psychiatric hospital, skilled nursing facility, jail, or prison); or e) **homeless** (homeless or emergency shelter). In the month preceding their index hospital stay (or program entry), large groups of MHICM veterans reported living in independent (N=2,316, 57.9%), extremely restrictive (N=1,070, 26.9%), or minimally restrictive (N=924, 23.2%) residences (see **Figure 2-5**). Fewer veterans reported living in moderately restrictive (N=382, 9.6%) residences or having been homeless (N=158, 4.0%). At follow-up, the numbers of veterans who had been homeless (N=17, 0.6%) or in extremely restrictive residences (N=172, 6.3%) had declined by more than seventy-five percent. There was little change in the proportion of clients who reported living independently (N=1,506, 54.5%) or in moderately restrictive residences (N=234, 8.5%), but fifty-one percent more veterans reported living in minimally restrictive residences (N=964, 35.1%). At the same time, client satisfaction with living arrangements and safety increased by 8.1% and 8.7%, respectively. These data reflect the fluidity of living arrangements for veterans with serious mental illness and team reliance on boarding home, foster care and supervised apartments to complement MHICM services in off-hours.

Using the items described above, a housing independence index was created to compare veteran-reported housing status before and after program entry. Client reported days spent at each level of housing independence were multiplied by a corresponding weight (Independent x 4, Minimally restrictive x 3, Moderately restrictive x 2, Extremely restrictive x 1, Homeless x 0). Overall, a comparison of client ratings, presented in **Table 2-23a**, revealed a statistically significant 13.3% gain in housing independence from pre- (N=3,953, mean = 3.0 ± 0.4) to post-entry (mean = 3.4 ± 0.6) (N=2,430; mean difference: 0.40, $t=16.23$, $p<0.0001$).

Work and Rehabilitation Activity

A small number of MHICM veterans (N=502 of 4,021; 12.5%) reported full- or part-time employment in the three years before program entry. An even smaller group (N=280, 7.0%) reported paid employment in the month before program entry (see **Figure 2-6**). Among all clients, paid work declined slightly from an average of 1.0 day at entry to 0.7 days at follow-up. Among paid veterans, paid days averaged 14.0 days at entry and 16.2 days at follow-up. Fewer veterans reported work as volunteers (N=178, 4.4%) or participants in “work-for-pay” (N=142, 3.5%) or formal (N=82, 2.1%)

⁶Paired t-test results for client ratings of quality of life (N=2,169, mean difference: 2.56, $t=18.7$, $p<0.0001$), satisfaction with VA mental health services (multi-item: N=2,105, mean difference: 0.84, $t=16.0$, $p<0.0001$); single item: N=1,966, mean difference: 0.35, $t=12.10$, $p<0.0001$), and satisfaction with MHICM services (N=2,217, mean difference: 0.58, $t=23.08$, $p<0.0001$) were all significantly positive.

vocational rehabilitation programs at entry. At follow-up, veteran reports of paid work (N=126, 4.6%) declined, while participation in volunteer (N=123, 4.8%), “work-for-pay” (N=130, 4.7%) and formal rehabilitation (N=69, 2.6%) programs increased marginally. The relative weakness of vocational outcomes for MHICM teams may reflect: 1) the absence of staff with vocational rehabilitation expertise on MHICM teams; 2) severe levels of impairment among MHICM veterans; and/or 3) low incentive for work among MHICM clients who receive extensive VA and Social Security benefits for disability. Anecdotally, some MHICM staff reported their clients were “too disabled” or “unmotivated” to work and were often refused admission by vocational rehabilitation services.

Satisfaction with VA Mental Health Services

Client ratings of the overall quality of VA mental health services (VAMHSAT, 3 items), presented in **Table 2-24**, showed a statistically significant 9.0% gain from pre- (N=3,643; mean: 9.5 ± 0.7) to post-entry (mean: 10.3 ± 0.9). Clients from 69 of 71 teams (97.2%) indicated greater satisfaction with VA mental health services at follow-up. Single-item comparison of client satisfaction with MHICM and general VA mental health services using a 5-point scale (0-very dissatisfied to 5-very satisfied), summarized in **Table 2-25**, found program participants favoring MHICM (N=3,744; mean: 3.7 ± 0.3) by almost 20% over general services (mean: 3.1 ± 0.3). Veterans on all 71 teams showed improved satisfaction after participation in MHICM. MHICM services, comprising the bulk of psychiatric care for most program clients, were positively associated with gains in overall satisfaction with VA mental health services, up by 11.8% (mean: 3.5 ± 0.8) at the time of follow-up.

Unit Costs

As its name suggests, Mental Health Intensive Case Management involves providing frequent services to veterans who are among the most seriously ill and most expensive to treat in the VA system. The extent of care required by this group, and the setting where services are delivered, have prompted low recommended client-to staff levels that, in turn, contribute most heavily to personnel and program expenses. Using FY 2004 program expenditures and data from previously presented tables, **Table 2-26** outlines rough program costs for various units of service. For 4,761 veterans in FY 2004, MHICM services cost about **\$7,105 per veteran**, an increase of 23% over original study data (\$5,793) unadjusted for inflation (Rosenheck, Neale, and Frisman, 1995) and 9% over FY 2003 costs (\$6,507). On the basis of filled positions (415.20 FTE) and FY 2004 personal service expenditures plus benefits (\$33.8M), the average annual cost per position was **\$76,890 per FTE** (salary plus benefits), 7% higher than FY 2003 (\$71,646). Adjusting total MHICM visits to reflect a full year of service for each veteran (a cumulative total of **329,554** visits for a year), the cost for MHICM services increased to **\$103 per visit**, 11% higher than FY 2003. MHICM cost increases for FY 2004 reflect rapid expansion of the program over the past three years. Although the numbers of teams (23, +47.9%), FTE (163.8, +65.2%), clients (1,572, +49.3%) and contacts (117,139, +55.1%) have increased substantially, the average team caseload per clinical FTE is somewhat lower (.70, -- 5.5%), consistent with the development of new teams that are still developing full client caseloads and have yet to achieve typical cost-benefit levels.

Outlier Review

MHICM teams were asked to review critical monitors and minimum standards where a team value was identified as an outlier (i.e., failed to meet the minimum standard threshold or differed statistically from the median site in the undesired direction). Minimum standards were based on VHA Directive 2000-034 and critical monitor outliers were based on MHICM program guidelines and principles. For each outlier on a critical monitor or minimum standard, the team was asked to identify a reason for outlier status from among five options and to explain and address it. The Outlier Review request and review form are included in **Appendix C**.

Negative outlier values are shaded in report tables and outlined (boxed) in summary tables. Critical monitor outliers are summarized by site across monitoring domains in **Table 2-27** (Site Performance) and within domains in **Table 2-28** (Team Structure), **Table 2-29** (Client Characteristics), **Table 2-30** (Clinical Process), and **Table 2-31** (Client Outcome). Minimum standards outliers are summarized by site in **Table 2-32 A&B**. Team outlier review responses are summarized in **Table 2-33** (Outlier Review Summary) and briefly described here.

Four teams operating in FY 2004 – Chicago IL, Chillicothe OH, Cleveland OH, and Topeka KS - had no outlier values. The 67 remaining teams accounted for 184 negative outliers (2.8 outliers per team), a rate comparable to FY 2003 (163 outliers {2.7 outliers per team} among 60 teams). Ten teams (14%) had five or more outliers, up from 6 teams (10%) in FY 2003. In order of frequency, outlier review responses from 67 teams indicated: (C) Problems in program implementation for which corrective action had been taken (Sites: 36 or 54% of responding sites; Responses: 65 or 35% of total outliers); (D) Problems in program implementation for which corrective action was planned (Sites: 36 or 54%; Responses: 65 or 35%); (A) Legitimate team differences that did not conflict with national program goals (Sites: 28 or 42%; Responses: 44 or 24%); (B) Local policies that conflicted with national program goals (Sites: 16 or 24%; Responses: 19 or 10%); and (E) Implementation problems for which no corrective action was planned (Sites: 5 or 8%; Responses: 8 or 4%).

By domain, Team Structure outliers remained the most common (91 outliers at 52 sites, 73%), followed by outliers in Clinical Process (59 outliers, 42 sites), Clinical Outcome (24 outliers, 21 sites), and Client Characteristics (11 outliers at 11 sites). By monitor, outliers were most common for Team Size (31), Unfilled FTE and Physician Support (22), Face-to-Face Contact (20), Client Discharge (18) and Intensity of Contact (14), and least likely for Psychotic Diagnosis and GAF (0), Location of Contact and Quality of Life (1) and Reported Symptoms (2). Results corroborate team reports of problems maintaining staff resources to provide intensive services for veterans with serious mental illness and general adherence to ACT fidelity standards.

Adherence to Minimum Standards

VHA Directive 2000-034 established procedural guidelines for MHICM teams that were operationalized in eight **minimum program standards**. FY 2004 outliers for MHICM minimum program standards (see page 16) are presented by site in Table 2-32A and B and reviewed here. Adherence was good or excellent (80% or better) for five standards and fair or poor (less than 80%) for the other three. Among standards with a higher adherence rate, all seventy-one teams (100%) reported that the majority of veterans they treated (Mean: 89%; Range: 61% to 100%) had psychiatric

diagnoses that included psychosis (i.e., schizophrenia, schizo-affective or bipolar disorder, other psychosis). Seventy teams indicated that the majority of their clients (Mean: 89%; Range: 45% to 100%) received most MHICM clinical services in community settings. Sixty-four teams (90%) reported providing rehabilitation services (e.g., client skills training) to at least one quarter of their clients (Mean: 49%; Range: 8% to 93%). Sixty teams (85%) indicated that a majority of their clients (Mean: 75%; Range: 22% to 100%) had 30 or more psychiatric inpatient hospital days in the year preceding program admission. Fifty-nine teams (83%) maintained client to staff ratios between 7:1 and 15:1 (Mean: 12.5; Range: 6.3 to 35.0).

Among standards with a lower adherence rate, fifty-three teams (75%) met the criterion of discharging fewer than 20 percent of their clients per year (Mean: 16%; Range: 2% to 36%). Fifty teams (73%) had at least weekly face-to-face contact with their clients (Mean: 1.3; Range: 0.43 to 2.92). Forty teams (56%) had 4 or more clinical FTEE available to provide community-based services (Mean: 4.8; Range: 1.2 to 11.5 FTEE). Non-adherence to the latter standards appeared to be largely a consequence of staff reallocation. Most of the teams that did not meet the staffing standard had been funded initially with four or more case manager positions but lost positions over the years when staff were detailed to other units, not replaced, or hiring was frozen. In many cases, staff losses coincided with higher caseloads and lower contact frequency. Eighteen of seventy-one MHICM teams (25%) met all eight minimum program standards in FY 2004, comparable with 15 teams (24%) in FY 2003 and 11 teams (21%) in FY 2002.

Transition to Lower Intensity Case Management Services

VHA Directive 2000-034 (Appendix E) defined a procedure for transitioning MHICM clients to lower intensity services. Teams may begin to assess client readiness for a lower level of care, after one year of MHICM services, using five criteria: “clinically stable, not abusing addictive substances, not relying on extensive inpatient or emergency services, capable of maintaining themselves in a community living situation, and independently participating in necessary treatments”. Clients who meet all criteria may be transitioned to less intensive MHICM services or to standard clinical services.

As mandated by the Directive, NEPEC began monitoring client transition to lower intensity services during FY 2000. Through FY 2002, 547 MHICM veterans were transitioned to less intensive services: 67% to lower intensity services by the MHICM team, 20% to low intensity services elsewhere, and 10% discharged without additional services. When transitioned, veterans were assessed as: clinically stable (80%); not abusing addictive substances (68%); not relying on extensive inpatient or emergency services (75%); capable of maintaining themselves in a community living situation (68%); and independently participating in necessary treatments (63%). These data indicate that up to one-third of transitioned veterans did not fully meet VHA Directive 2000-034 criteria, though the majority continued to receive low intensity services from the MHICM team. Transitioned veterans continued to receive a range of clinical services, including case management (63%), day treatment (13%), outpatient mental health therapy (47%), outpatient medication management (68%), substance abuse services (8%), residential services (24%), vocational services (10%), inpatient care (11%), or nursing home care (7%). Only 28 veterans (5%) were later restored to regular MHICM services (most re-hospitalized) because of real or imminent risk to themselves or others, impaired ability to care for self, and unwillingness or inability to participate in needed treatments. Teams reported that 14 clients (3%) may have been at greater risk due to transition to less intensive services.

At the end of FY 2004, 351 veterans (8%) were receiving low intensity case management services from 48 MHICM teams (62%). During the year, 137 MHICM veterans (3% of 4,761) were transitioned to less intensive services: 42% to lower intensity MHICM services, 32% to low intensity services elsewhere, and 15% discharged without additional services. Eight veterans were later restored to regular MHICM services due to real or imminent risk to themselves or others. When transitioned, veterans were assessed as: clinically stable (75%); not abusing addictive substances (57%); not relying on extensive inpatient or emergency services (68%); capable of maintaining themselves in a community living situation (62%); and independently participating in necessary treatments (57%). Transitioned veterans continued to receive case management (44%), day treatment (14%), outpatient mental health therapy (62%), outpatient medication management (64%), substance abuse services (10%), residential services (30%), vocational services (8%), inpatient care (10%), or nursing home care (8%). Five clients were viewed as possibly at greater risk due to transition to less intensive services.

MHICM VERA Complex Class Status

In FY 2002, MHICM veterans became eligible for Complex Class reimbursement status under VERA (Veterans Equitable Resource Allocation) if they were registered in a MHICM program (participated in NEPEC program monitoring) and had 41 or more clinic stops (visits) under DSS Identifier 552 during the Fiscal Year. For FY 2004, average Complex Care funding under VERA was \$35,957 per veteran. FY 2004 Allocation Resource Center data indicate that 2,715 (57.4%) of 4,761 MHICM veterans covered by this report were included in the MHICM complex class reimbursement category. An additional 1,330 veterans (27.9%) were included in the Chronic Mental Illness patient class, for a total of 4,045 MHICM veterans receiving complex class reimbursement for serious mental illness, and 319 veterans qualified for MHICM complex class reimbursement at sites not covered by this report. **Appendix G** presents totals for MHICM complex class veterans for FY 2004 by facility.

MHICM Services for MHICM and Non-MHICM Veterans

MHICM visits are recorded in VA outpatient databases under DSS Identifier or Stop Code 552. Non-MHICM or general case management contacts (typically low intensity) are reported under identifier 564. FY 2004 workload data for MHICM veterans are summarized in **Appendix E** (see also Table 2-14) and for non-MHICM veterans in **Appendix F**. For the 71 teams covered by this report, **MHICM veterans** (N=4,469) received 252,271 regular MHICM (“high intensity”) visits in FY 2004, an average of 56 visits per veteran (Appendix E). MHICM visits represented 99% of total client services for this group. A small minority of MHICM veterans (N=186 or 4%), at nineteen sites, received general case management visits (966), about 5 visits per client. A large number of **Non-MHICM veterans** (N=2,930) were credited with MHICM visits, typically at facilities with established or developing MHICM teams. Contacts for these veterans (39,489 visits) made up a smaller portion (63%) of total case management services and averaged 13 visits per veteran. Most of these veterans were presumably seen for assessment or screening visits or clinic stop code 552 (MHICM visit) was incorrectly assigned. Only veterans who are fully enrolled or registered in the performance monitoring system are considered MHICM participants under VHA Directive 2000-034. A substantial group of non-MHICM veterans (N=2,581) received general case management services (22,882 visits), an average of 9 visits per veteran. Many of these contacts were reported by facilities without a MHICM team.

Program Performance Trends: 1997 to 2004

This is the seventh MHICM performance monitoring report, dating back to FY 1997. Beginning with this report, we will summarize trends in program performance by monitoring domain, comparing the latest results (FY 2004) with those for the first report (FY 1997) and the three most recent years (FY 2001 to FY 2003). These data are presented in **Appendix H**.

Data on **team structure** show a significant increase in the number of MHICM teams (+95%) and clients (+136%), as well as program expenditures (+166%) since 1997. Most of this change has come since October 2000 with implementation of VHA Directive 200-034. The number of MHICM staff positions also increased but at a lower rate (+84%). Positions remain filled at about the same level as last year (+2%). The percentage of teams with at least one team member detailed to another service has increased dramatically (+100%). Program cost per client increased (+17%, unadjusted for inflation) and the client to staff ratio held steady (2%).

Client characteristics data indicate an increase in the number of veterans from minority racial/ethnic groups (+14%) since 1997. Reflecting VHA's shift toward outpatient services, client days in hospital have decreased (-41%) and the proportions of clients with 30 or more hospital days (-18%) and 2 or more years of lifetime hospitalization (-25%) also have declined. The vast majority of MHICM clients continue to have a psychotic diagnosis (2%). Despite some targeting of clients with co-occurring substance use, that group has decreased somewhat (-16%) since 1997. Client participation in paid employment prior to entry is unchanged (0%) while receipt of public support income has increased (+4%).

Service delivery data provide evidence that MHICM veterans continue to be contacted weekly (+4%) if less frequently (-19%) than in 1997. FY 2004 contacts remained at the FY 2001 level. More clients receive the majority of their services in community settings (+14%) than in 1997. The rate of discharge is unchanged (0%) even as more veterans (currently 8%) are transitioned to less intensive services by the team. Veteran ratings of their therapeutic alliance with MHICM staff have increased (+27%) since 1997, and team fidelity to assertive community treatment principles has remained steady (4.0, 0% change).

Client outcome data show sizeable improvements in percentage reduction for both observed (100%) and reported (+117%) symptoms at follow-up, since 1997. Quality of life ratings have improved (+25%) and satisfaction with MHICM services has remained high (+1%). Although client inpatient days prior to program entry continue to decline (-39% overall, -9% in the past year), the percentage reduction in client hospital days at follow-up has increased (+11%).

Consistent with VHA's commitment to expand access to community-based services, the MHICM program has grown since 1997. MHICM has benefited from network and facility support and a national initiative to implement VHA Directive 2000-034. Review of outliers and team reports continue to underscore the importance of attention to team and caseload size and staff training. Performance monitoring data show that MHICM teams continue to target veterans who need intensive support, providing them with quality services in community settings. After seven years of MHICM performance monitoring, client outcomes are strong and satisfaction remains high.

Summary and Conclusions:

Development of Mental Health Intensive Case Management services in VA has followed a model sequence of problem identification, program development, evaluation, and dissemination (Rosenheck, 2001). Modeled on evidence-based, “best practice” programs in widespread use elsewhere in the nation (Rosenheck and Neale, 2001; Phillips et al., 2001), the MHICM program is a well-defined intervention that meets local needs within its operational parameters. A rigorous study demonstrated the program’s cost-effectiveness and long-term benefits in VA settings, as well as the need for training and monitoring to assure proper implementation. Both VA and non-VA studies show program benefits are not likely to be attained unless team operation is carefully monitored (Mueser et al., 1998). MHICM has been successfully implemented at more than 80 VA healthcare systems and site-by-site performance monitoring data show the program continues to provide effective and efficient services to deserving veterans in great need.

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Table 2-1. VA MHICM Program Monitors

Monitoring Domain	Program Monitor	Unit	Report Table^	Program Objective	Critical Monitor
I. Structure	1. Total FTE allocated to date	#	2-3	1	
	2. Actual FTEE filled (September 30, 2003)	#	2-5	1	
	3. % FTE utilized	%	2-5	1	
	4. Total funds (PS, AO, AS, TOT) allocated	\$	2-3	1	
	5. Actual funds expended (FY 2003)	\$	2-4	1	
	6. Medical support (.2MD, 1.0RN)	Y/N	2-6	1	*
	7. Clinical FTEE	#	2-6	1	+
	8. FTE unfilled or lagged GTE 6 months	Y/N	2-5	1	*
	9. FTE assigned to non-MHICM activities	Y/N	2-5	1	
	10. # Total veterans enrolled (9/30/03)	#	2-6	1	
	11. Caseload size (vet/staff: 7-15/Clinical FTE)	ratio	2-6	1	*+
II. Client	12. % Caseload entered as inpatient	%	2-8	1	
	13. % Caseload w/CLOS GTE 30 (yr of entry)	%	2-8/10	1	*+
	14. % Caseload w/psychotic diagnosis at entry	%	2-8/10	1	*+
	15. % Age at entry (by category)	%	2-7	na	
	16. % Minority status	%	2-7	na	
	17. % Dual diagnosis	%	2-8	na	
	18. Lifetime psych hospital use (% GT 2 yrs)	%	2-10	3	
	19. % Receiving public support (any source)	%	2-8/9	1	
	20. % Receiving VA compensation or pension	%	2-8/9	1	
	21. % Employed (FT/PT) in past 3 years	%	2-7	1	
	22. Global functioning at entry (% GAF GTE 50)	%	2-11	4	*
	23. IADL skills (% domains rarely/never)	%	2-11	4	
	24. Severity of illness (Mean BPRS score)	#	2-11	2	
III. Process	25. # New veterans added	#	2-12	1	
	26. % Clients terminated (Continuity)	%	2-12	1	*+
	27. % Clients seen weekly + (Frequency)	%	2-13	1	
	28. % Clients seen 61+mins/wk seen (Intensity)	%	2-13	1	*
	29. % Clients seen 61%+ community (Location)	%	2-13	1	*+
	30. # Face-to-face contacts/wk (Adj mean/wk)	#	2-14	1	*+~
	31. % Clients seen for rehabilitation	%	2-15	4	+
	32. % Clients seen for substance abuse	%	2-15	2	
	33. % Change therapeutic alliance	%	2-16	5	
	34. % Fidelity to ACT Model	%	2-17	1	
IV. Outcome	35. # Mean VA hospital days post-entry (6 mos)	#	2-18	3	*
	36. % Change in VA hospital days (6 mos)	%	2-18	3	
	37. \$ Estimated change in VA healthcare cost	\$	2-18	6	
	38. % Client symptoms improved (BPRS)	%	2-19	2	*
	39. % Client symptoms improved (BSI)	%	2-20	2	*
	40. % Client functioning improved (GAF)	%	2-21	4	*
	41. % Client functioning improved (IADL)	%	2-22	4	*
	42. % Client quality of life improved (QOLI)	%	2-23	4	*
	43. % Client satisfaction: VA mental health care	%	2-24	5	
	44. % Client satisfaction: MHICM vs. VA MH care	%	2-25	5	*
V. Cost	45. \$ Cost per veteran	\$	2-26	6	
	46. \$ Cost per FTEE	\$	2-26	6	
	47. \$ Cost per visit	\$	2-26	6	

*Critical MHICM monitor; + Minimum program standard; ~ Minimum standard replaces critical monitor standard.

^Chapter 2 summarizes table data; Appendix D provides a complete set of column definitions for all tables.

TABLE 2-2. MHICM PROGRAMS THROUGH FY 2004

VISN	SITE NAME ~	SITE CODE	SITE TYPE	MHICM START-UP YEAR
1	BEDFORD	518	NP	1995
1	BROCKTON	523A5	NP	1987
1	TOGUS	402	GM&S	1995
1	WEST HAVEN	689	GM&S	1987
2	ALBANY	528A8	GM&S	1987
2	BUFFALO	528	GM&S	1987
2	CANANDAIGUA	528A5	NP	1987
2	SYRACUSE	528A7	GM&S	1987
3	BROOKLYN	630A4	GM&S	1995
3	MONTROSE	620	NP	1987
3	NEW JERSEY	561	GM&S	1995
3	NORTH PORT	632	NP	2001
4	COATESVILLE	542	NP	1995
4	PITTSBURGH	646A5	NP	1994
5	MARTINSBURG	613	GM&S	2004
5	PERRY POINT	512A5	NP	1994
6	FAYETTEVILLE	565	GM&S	2002
6	HAMPTON	590	GM&S	2002
6	SALEM	658	NP	2002
6	SALISBURY	659	NP	1994
7	ATLANTA	508	GM&S	1995
7	AUGUSTA	509	NP	1995
7	BIRMINGHAM	521	GM&S	2004
7	TUSCALOOSA	679	NP	2001
7	TUSKEGEE	619A4	NP	1995
8	GAINESVILLE	573	GM&S	1995
8	MIAMI	546	GM&S	1994
8	TAMPA	673	GM&S	1995
10	CHILLICOTHE	538	NP	1995
10	CINCINNATI	539	GM&S	1999
10	CLEVELAND	541	GM&S	1994
10	COLUMBUS	757	GM&S	1999
10	DAYTON	552	GM&S	1999
10	YOUNGSTOWN	541B2	GM&S	2001
11	ANN ARBOR	506	GM&S	1995
11	BATTLE CREEK	515	NP	1995
11	DETROIT	553	GM&S	1998
11	NORTHERN INDIANA	610	NP	2001
12	CHICAGO-WEST SIDE	537	GM&S	1992
12	MADISON	607	GM&S	1995
12	MILWAUKEE	695	GM&S	2001
12	NORTH CHICAGO	556	NP	1995
12	TOMAH	676	NP	2002
15	ST. LOUIS	657	GM&S	2003
15	TOPEKA	677	NP	2002
16	GULF COAST	520	GM&S	2001
16	HOUSTON	580	GM&S	2001
16	LITTLE ROCK	598	GM&S	2000
16	NEW ORLEANS	629	GM&S	2001
17	DALLAS	549	GM&S	1995
17	TEMPLE (WACO)	685	NP	1995
18	ALBUQUERQUE	501	GM&S	2003
18	PHOENIX	644	GM&S	2002
19	DENVER	554	GM&S	1995
19	GRAND JUNCTION	575	GM&S	2000
19	SALT LAKE CITY	660	GM&S	2000

TABLE 2-2. MHICM PROGRAMS THROUGH FY 2004

VISN	SITE NAME ~	SITE CODE	SITE TYPE	MHICM START-UP YEAR
19	SHERIDAN	666	NP	2001
19	SOUTHERN COLORADO	567	NP	2000
20	AMERICAN LAKE	663A4	NP	1994
20	BOISE	531	GM&S	1995
20	PORTLAND	648	GM&S	1992
20	SEATTLE	663	GM&S	1995
21	PALO ALTO	640	GM&S	2002
21	SAN FRANCISCO	662	GM&S	1995
22	GREATER LOS ANGELES	691	GM&S	1994
22	SAN DIEGO	664	GM&S	2003
23	IOWA CITY	636A8	GM&S	2003
23	KNOXVILLE	636A7	NP	1999
23	MINNEAPOLIS	618	GM&S	1995
23	OMAHA	636	GM&S	2003
23	ST.CLOUD	656	NP	2001

~MHICM teams (N=7) with insufficient data to be included in this Report:
Philadelphia, Baltimore, Washington DC, Columbia, Mountain Home, Danville
and Fort Harrison.

TABLE 2-3. ALLOCATED STAFF AND FUNDS (ORIGINAL DOLLARS)

VISN	SITE NAME	ALLOCATED FTE	PERSONAL SERVICE	ALL OTHER	ADMIN SUPPORT	TOTAL PROGRAM \$
1	BEDFORD	6.20	\$582,020	\$15,000	\$30,000	\$627,020
1	BROCKTON	10.50	\$392,315	\$52,006	\$0	\$444,321
1	TOGUS	3.50	\$200,000	\$15,000	\$20,000	\$235,000
1	WEST HAVEN	11.00	\$404,862	\$27,000	\$14,686	\$446,548
2	ALBANY	10.00	\$341,000	\$1,985	\$0	\$342,985
2	BUFFALO	8.50	\$273,000	\$12,000	\$0	\$285,000
2	CANANDAIGUA	11.60	\$343,052	\$42,844	\$0	\$385,896
2	SYRACUSE	4.30	\$174,671	\$5,200	\$11,500	\$191,371
3	BROOKLYN	6.20	\$300,000	\$15,000	\$30,000	\$345,000
3	MONTROSE	4.50	\$225,144	\$85,456	\$0	\$310,600
3	NEW JERSEY	7.70	\$562,527	\$23,977	\$26,000	\$612,504
3	NORTHPORT	7.03	\$601,865	\$29,553	\$0	\$631,418
4	COATESVILLE	6.20	\$300,000	\$15,000	\$30,000	\$345,000
4	PITTSBURGH	6.50	\$300,000	\$25,000	\$45,000	\$370,000
5	MARTINSBURG	4.70	\$329,499	\$14,883	\$0	\$344,382
5	PERRY POINT	6.50	\$315,326	\$25,000	\$45,000	\$385,326
6	FAYETTEVILLE	3.00	\$295,061	\$15,034	\$0	\$310,095
6	HAMPTON	4.64	\$319,021	\$22,393	\$0	\$341,414
6	SALEM	4.20	\$300,020	\$0	\$0	\$300,020
6	SALISBURY	6.50	\$300,000	\$50,000	\$45,000	\$395,000
7	ATLANTA	5.20	\$260,000	\$15,000	\$26,000	\$301,000
7	AUGUSTA	6.20	\$288,052	\$15,000	\$28,805	\$331,857
7	BIRMINGHAM	4.50	\$219,081	\$8,353	\$0	\$227,434
7	TUSCALOOSA	8.10	\$541,543	\$18,798	\$0	\$560,341
7	TUSKEGEE	3.50	\$200,000	\$15,000	\$20,000	\$235,000
8	GAINESVILLE	5.20	\$282,500	\$15,000	\$26,000	\$323,500
8	MIAMI	7.30	\$364,456	\$23,620	\$25,000	\$413,076
8	TAMPA	6.00	\$310,010	\$16,817	\$0	\$326,827
10	CHILLICOTHE	6.20	\$300,000	\$15,000	\$30,000	\$345,000
10	CINCINNATI	4.00	\$130,000	\$9,000	\$0	\$139,000
10	CLEVELAND	6.50	\$300,000	\$25,000	\$45,000	\$370,000
10	COLUMBUS	4.00	\$130,000	\$9,000	\$0	\$139,000
10	DAYTON	4.00	\$130,000	\$9,000	\$0	\$139,000
10	YOUNGSTOWN	4.33	\$309,266	\$11,616	\$0	\$320,882
11	ANN ARBOR	5.20	\$240,000	\$15,000	\$24,000	\$279,000
11	BATTLE CREEK	6.20	\$300,000	\$15,000	\$30,000	\$345,000
11	DETROIT	9.30	\$325,000	\$75,000	\$0	\$400,000
11	NORTHERN INDIANA	6.20	\$372,474	\$11,436	\$0	\$383,910
12	CHICAGO-WEST SIDE	7.30	\$267,600	\$24,400	\$0	\$292,000
12	MADISON	3.50	\$228,000	\$15,000	\$20,000	\$263,000
12	MILWAUKEE	4.95	\$343,727	\$25,246	\$0	\$368,973
12	NORTH CHICAGO	6.20	\$300,000	\$15,000	\$30,000	\$345,000
12	TOMAH	3.88	\$259,438	\$13,351	\$0	\$272,789
15	ST. LOUIS	5.00	\$290,123	\$17,701	\$0	\$307,824
15	TOPEKA	9.50	\$628,521	\$0	\$0	\$628,521
16	GULF COAST	4.20	\$345,606	\$13,308	\$0	\$358,914
16	HOUSTON	6.00	\$457,160	\$37,896	\$0	\$495,056
16	LITTLE ROCK	4.00	\$305,889	\$62,152	\$0	\$368,041
16	NEW ORLEANS	4.84	\$397,012	\$8,585	\$0	\$405,597
17	DALLAS	6.50	\$303,107	\$15,000	\$28,000	\$346,107
17	TEMPLE (WACO)	4.00	\$163,000	\$15,000	\$16,300	\$194,300
18	ALBUQUERQUE	5.90	\$251,480	\$10,820	\$0	\$262,300
18	PHOENIX	8.00	\$416,084	\$16,179	\$0	\$432,263
19	DENVER	6.20	\$300,000	\$15,000	\$30,000	\$345,000
19	GRAND JUNCTION	3.15	\$253,661	\$3,810	\$0	\$257,471
19	SALT LAKE CITY	5.75	\$316,304	\$6,445	\$0	\$322,749
19	SHERIDAN		\$118,187	\$14,345		\$132,532

TABLE 2-3. ALLOCATED STAFF AND FUNDS (ORIGINAL DOLLARS)

VISN	SITE NAME	ALLOCATED FTE	PERSONAL SERVICE	ALL OTHER	ADMIN SUPPORT	TOTAL PROGRAM \$
19	SOUTHERN COLORADO	7.60	\$256,396	\$152,121	\$0	\$408,517
20	AMERICAN LAKE	6.50	\$280,000	\$25,000	\$45,000	\$350,000
20	BOISE	3.60	\$236,000	\$8,100	\$23,600	\$267,700
20	PORTLAND	7.00	\$268,000	\$19,500	\$0	\$287,500
20	SEATTLE	5.20	\$260,000	\$15,000	\$26,000	\$301,000
21	PALO ALTO	3.80	\$303,085	\$7,740	\$0	\$310,825
21	SAN FRANCISCO	6.50	\$300,000	\$15,000	\$30,000	\$345,000
22	GREATER LOS ANGELES	6.50	\$300,000	\$25,000	\$45,000	\$370,000
22	SAN DIEGO	6.20	\$157,113	\$7,603	\$0	\$164,716
23	IOWA CITY	4.50	\$276,281	\$33,736	\$0	\$310,017
23	KNOXVILLE	7.85	\$436,195	\$14,786	\$0	\$450,981
23	MINNEAPOLIS	5.20	\$260,000	\$15,000	\$26,000	\$301,000
23	OMAHA	5.20	\$325,156	\$13,522	\$0	\$338,678
23	ST.CLOUD	3.70	\$290,302	\$18,530	\$0	\$308,832
	ALL SITES	413.42	\$21,755,192	\$1,514,847	\$871,891	\$24,141,930
	SITE AVERAGE	5.91	\$306,411	\$21,336	\$12,822	\$340,027
	SITE STD. DEV	1.90	\$102,484	\$21,762	\$15,688	\$106,065

Source: MSHSG Resource tables and initial site-generated Annual Reports.

~MHICM teams (N=7) with insufficient data to be included in this Report:

Philadelphia, Baltimore, Washington, DC, Columbia, Mountain Home, Danville, and Fort Harrison.

TABLE 2-4. FY 2004 PROGRAM EXPENDITURES

VISN	SITE NAME	FY 2004 FILLED FTE	FY 2004 P/S EXPEND.	FY 2004 AO EXPEND.	FY 2004 TOTAL EXPEND.
1	Bedford	13.00	\$1,026,711	\$26,034	\$1,052,745
1	Brockton	5.93	\$429,964	\$0	\$429,964
1	Togus	3.30	\$273,299	\$9,141	\$282,440
1	West Haven	5.83	\$478,662	\$25,539	\$504,200
2	Albany	4.85	\$375,475	\$788	\$376,263
2	Buffalo	7.60	\$453,328	\$10,329	\$463,657
2	Canandaigua	9.80	\$630,031	\$30,273	\$660,304
2	Syracuse	3.75	\$224,012	\$0	\$224,012
3	Brooklyn	4.40	\$360,845	\$12,967	\$373,812
3	Montrose	8.60	\$882,690	\$12,083	\$894,773
3	New Jersey	8.90	\$752,623	\$23,875	\$776,498
3	Northport	6.90	\$627,687	\$29,084	\$656,771
4	Coatesville	6.20	\$402,444	\$4,977	\$407,421
4	Pittsburgh	9.10	\$644,663	\$3,590	\$648,253
5	Martinsburg	3.00	\$196,691	\$169	\$196,860
5	Perry Point	6.00	\$480,753	\$16,824	\$497,577
6	Fayetteville	4.10	\$334,730	\$12,581	\$347,311
6	Hampton	4.30	\$388,671	\$20,645	\$409,316
6	Salem	4.00	\$369,888	\$5,528	\$375,416
6	Salisbury	3.20	\$280,215	\$6,600	\$286,815
7	Atlanta	6.20	\$528,930	\$16,254	\$545,184
7	Augusta	2.75	\$263,809	\$1,500	\$265,309
7	Birmingham	4.50	\$219,081	\$8,353	\$227,434
7	Tuscaloosa	8.10	\$547,782	\$22,042	\$569,824
7	Tuskegee	5.00	\$378,714	\$23,280	\$401,994
8	Gainesville	6.20	\$352,507	\$47,221	\$399,728
8	Miami	4.25	\$715,383	\$19,649	\$735,032
8	Tampa	5.00	\$310,010	\$16,817	\$326,827
10	Chillicothe	7.10	\$630,582	\$19,211	\$649,793
10	Cincinnati	9.30	\$523,232	\$91,725	\$614,957
10	Cleveland	15.00	\$1,423,674	\$42,830	\$1,466,504
10	Columbus	2.66	\$242,247	\$16,760	\$259,007
10	Dayton	10.50	\$619,232	\$108,906	\$728,138
10	Youngstown	3.85	\$420,907	\$11,080	\$431,987
11	Ann Arbor	5.20	\$355,355	\$42,572	\$397,927
11	Battle Creek	5.20	\$423,053	\$20,510	\$443,563
11	Detroit	7.92	\$454,663	\$6,500	\$461,163
11	Northern Indiana	7.80	\$528,810	\$68,410	\$597,220
12	Chicago-West Side	6.25	\$427,109	\$0	\$427,109
12	Madison	4.63	\$406,843	\$44,401	\$451,244
12	Milwaukee	4.95	\$343,853	\$19,026	\$362,879
12	North Chicago	10.50	\$899,219	\$28,425	\$927,644
12	Tomah	3.85	\$288,437	\$6,613	\$295,050
15	St. Louis	3.00	\$337,732	\$20,221	\$357,953
15	Topeka	9.00	\$650,070	\$0	\$650,070
16	Gulf Coast	5.70	\$387,229	\$5,537	\$392,766
16	Houston	5.50	\$540,933	\$19,436	\$560,369
16	Little Rock	5.00	\$415,794	\$8,679	\$424,473
16	New Orleans	4.88	\$427,775	\$9,594	\$437,369
17	Dallas	8.00	\$533,666	\$20,768	\$554,434
17	Temple (Waco)	5.00	\$304,763	\$33,201	\$337,964
18	Albuquerque	7.00	\$468,253	\$24,930	\$493,183
18	Phoenix	5.60	\$416,084	\$16,179	\$432,263
19	Denver	6.50	\$454,387	\$1,197	\$455,584
19	Grand Junction	4.00	\$202,920	\$4,200	\$207,120
19	Salt Lake City	4.75	\$364,756	\$11,919	\$376,675

TABLE 2-4. FY 2004 PROGRAM EXPENDITURES

VISN	SITE NAME	FY 2004 FILLED FTE	FY 2004 P/S EXPEND.	FY 2004 AO EXPEND.	FY 2004 TOTAL EXPEND.
19	Sheridan	1.50	\$118,187	\$14,345	\$132,532
19	Southern Colorado	6.25	\$493,716	\$93,076	\$586,792
20	American Lake	4.90	\$368,094	\$1,300	\$369,394
20	Boise	4.10	\$269,903	\$24,316	\$294,219
20	Portland	6.80	\$629,520	\$20,581	\$650,101
20	Seattle	4.10	\$245,236	\$1,300	\$246,536
21	Palo Alto	3.20	\$450,056	\$8,400	\$458,456
21	San Francisco	3.70	\$412,335	\$22,520	\$434,855
22	Greater Los Angeles	5.00	\$471,120	\$19,240	\$490,360
22	San Diego	4.20	\$436,468	\$17,956	\$454,425
23	Iowa City	5.30	\$359,280	\$39,377	\$398,657
23	Knoxville	8.35	\$556,459	\$35,603	\$592,062
23	Minneapolis	6.20	\$441,427	\$14,310	\$455,737
23	Omaha	5.00	\$366,732	\$19,660	\$386,392
23	St. Cloud	3.20	\$326,608	\$18,050	\$344,658
ALL SITES		415.20	\$32,366,317	\$1,459,007	\$33,825,324
SITE AVERAGE		5.85	\$455,864	\$20,549	\$476,413
SITE STD. DEV		2.42	\$201,600	\$20,863	\$208,452

*Expenditures include space rental.

~MHICM teams (N=7) with insufficient data to be included in this Report: Philadelphia, Baltimore, Washington, DC, Columbia, Mountain Home, Danville and Fort Harrison.

Source: MHICM Local Progress Reports FY2004

TABLE 2-5. UTILIZATION OF STAFF RESOURCES

VISN	SITE NAME	ALLOCATED FTE	FY FILLED FTE	% FTE UTILIZED	SEPT. CLINICAL FTE^	FTE UNFILLED GTE 6 MO.	FTE ASSIGNED TO NON-MHICM
1	Bedford	13.00	13.00	100.0%	10.50	N	N
1	Brockton	5.93	5.93	100.0%	5.51	N	Y
1	Togus	3.30	3.30	100.0%	2.70	N	N
1	West Haven	9.13	5.83	63.9%	5.20	Y	N
2	Albany	5.85	4.85	82.9%	3.25	Y	N
2	Buffalo	7.60	7.60	100.0%	6.00	N	N
2	Canandaigua	9.80	9.80	100.0%	9.30	N	N
2	Syracuse	3.75	3.75	100.0%	3.00	N	Y
3	Brooklyn	6.40	4.40	68.8%	3.90	Y	N
3	Montrose	9.60	8.60	89.6%	6.50	Y	N
3	New Jersey	8.90	8.90	100.0%	8.50	N	Y
3	Northport	6.90	6.90	100.0%	6.60	N	N
4	Coatesville	6.20	6.20	100.0%	5.80	N	N
4	Pittsburgh	9.10	9.10	100.0%	7.50	N	Y
5	Martinsburg	4.00	3.00	75.0%	3.00	Y	N
5	Perry Point	8.00	6.00	75.0%	4.25	Y	N
6	Fayetteville	4.10	4.10	100.0%	3.40	N	Y
6	Hampton	5.30	4.30	81.1%	4.50	N	N
6	Salem	4.50	4.00	88.9%	3.00	Y	Y
6	Salisbury	4.20	3.20	76.2%	2.50	Y	N
7	Atlanta	7.20	6.20	86.1%	5.50	Y	Y
7	Augusta	6.75	2.75	40.7%	2.00	Y	N
7	Birmingham	4.50	4.50	100.0%	3.50	N	N
7	Tuscaloosa	8.10	8.10	100.0%	4.00	N	N
7	Tuskegee	6.00	5.00	83.3%	4.50	Y	N
8	Gainesville	6.70	6.20	92.5%	3.50	N	N
8	Miami	6.25	4.25	68.0%	2.50	Y	N
8	Tampa	6.00	5.00	83.3%	3.50	N	N
10	Chillicothe	7.60	7.10	93.4%	7.00	N	N
10	Cincinnati	9.30	9.30	100.0%	7.50	N	N
10	Cleveland	15.00	15.00	100.0%	11.50	N	N
10	Columbus	3.66	2.66	72.7%	2.33	Y	N
10	Dayton	12.50	10.50	84.0%	9.00	Y	Y
10	Youngstown	3.85	3.85	100.0%	3.10	N	N
11	Ann Arbor	5.20	5.20	100.0%	3.50	N	N
11	Battle Creek	6.20	5.20	83.9%	4.00	Y	N
11	Detroit	7.92	7.92	100.0%	7.00	N	N
11	Northern Indiana	8.80	7.80	88.6%	6.00	Y	N
12	Chicago-West Side	6.25	6.25	100.0%	5.50	N	N
12	Madison	4.63	4.63	100.0%	3.30	N	N
12	Milwaukee	4.95	4.95	100.0%	3.50	N	N
12	North Chicago	13.00	10.50	80.8%	8.50	Y	Y
12	Tomah	3.85	3.85	100.0%	3.75	N	N
15	St. Louis	5.00	3.00	60.0%	2.50	Y	N
15	Topeka	9.00	9.00	100.0%	7.75	N	N
16	Gulf Coast	5.70	5.70	100.0%	4.50	N	Y
16	Houston	5.50	5.50	100.0%	4.50	N	N
16	Little Rock	5.00	5.00	100.0%	4.00	N	N
16	New Orleans	4.88	4.88	100.0%	3.50	N	N
17	Dallas	8.00	8.00	100.0%	6.50	N	N
17	Temple (Waco)	5.00	5.00	100.0%	4.50	N	N
18	Albuquerque	7.00	7.00	100.0%	4.50	N	N
18	Phoenix	5.60	5.60	100.0%	5.60	N	N
19	Denver	6.50	6.50	100.0%	5.50	N	N
19	Grand Junction	4.00	4.00	100.0%	3.50	N	N

TABLE 2-5. UTILIZATION OF STAFF RESOURCES

VISN	SITE NAME	ALLOCATED FTE	FY FILLED FTE	% FTE UTILIZED	SEPT. CLINICAL FTE^	FTE UNFILLED GTE 6 MO.	FTE ASSIGNED TO NON-MHICM
19	Salt Lake City	5.75	4.75	82.6%	4.50	N	Y
19	Sheridan	1.50	1.50	100.0%	1.20	N	N
19	Southern Colorado	6.25	6.25	100.0%	5.50	N	N
20	American Lake	4.90	4.90	100.0%	4.00	N	N
20	Boise	4.10	4.10	100.0%	3.00	N	N
20	Portland	6.80	6.80	100.0%	5.60	N	N
20	Seattle	5.10	4.10	80.4%	3.45	Y	N
21	Palo Alto	3.70	3.20	86.5%	3.00	Y	N
21	San Francisco	3.70	3.70	100.0%	3.00	N	N
22	Greater Los Angeles	6.00	5.00	83.3%	3.50	N	N
22	San Diego	6.20	4.20	67.7%	2.50	Y	N
23	Iowa City	5.30	5.30	100.0%	4.00	N	N
23	Knoxville	8.60	8.35	97.1%	7.00	Y	N
23	Minneapolis	6.20	6.20	100.0%	4.50	N	N
23	Omaha	5.00	5.00	100.0%	3.50	N	N
23	St. Cloud	3.20	3.20	100.0%	3.10	N	N
ALL SITES		453.25	415.20	91.6%	337.59		
SITE AVERAGE		6.38	5.85	91.8%	4.75	31.0%	15.5%
SITE STD. DEV		2.46	2.42	12.5%	2.07		

* Extended staff vacancy in FY 2004.

^ Outlined values deviate from minimum staffing standard (4.0 Clinical FTE) or expected staffing.

~MHICM teams (N=7) with insufficient data to be included in this Report: Philadelphia,

Baltimore, Washington, DC, Columbia, Mountain Home, Danville and Fort Harrison..

Source: September 2004 FTE/Caseload Report

TABLE 2-6. CLINICAL STAFF AND CASELOAD

VISN	SITE NAME	*MEDICAL SUPPORT		CLINICAL FTE	9/04 TOTAL # VETS	9/04 CASELOAD per CLIN FTE^	TEAM TARGET CASELOAD	
		MD	RN				MIN	MAX
1	Bedford	Y	Y	10.5	119	11.33	74	158
1	Brockton	Y	N	5.51	69	13.40	39	83
1	Togus	Y	Y	2.7	25	9.26	19	41
1	West Haven	Y	N	5.2	55	10.58	36	78
2	Albany	Y	Y	3.25	50	15.38	23	49
2	Buffalo	Y	Y	6	85	14.17	42	90
2	Canandaigua	N	Y	9.3	98	10.54	65	140
2	Syracuse	Y	N	3	44	14.67	21	45
3	Brooklyn	N	Y	3.9	48	12.31	27	59
3	Montrose	Y	Y	6.5	86	13.23	46	98
3	New Jersey	Y	Y	8.5	83	9.77	60	128
3	Northport	N	Y	6.6	93	14.09	46	99
4	Coatesville	N	Y	5.8	87	15.00	41	87
4	Pittsburgh	Y	Y	7.5	122	16.27	53	113
5	Martinsburg	N	Y	3	25	8.33	21	45
5	Perry Point	Y	N	4.25	64	15.06	30	64
6	Fayetteville	Y	Y	3.4	26	7.65	24	51
6	Hampton	Y	Y	4.5	50	11.11	32	68
6	Salem	Y	Y	3	35	11.67	21	45
6	Salisbury	Y	Y	2.5	30	12.00	18	38
7	Atlanta	Y	Y	5.5	43	7.82	39	83
7	Augusta	N	Y	2	70	35.00	14	30
7	Birmingham	Y	Y	3.5	22	6.29	25	53
7	Tuscaloosa	N	Y	4	63	15.75	28	60
7	Tuskegee	N	Y	4.5	51	11.33	32	68
8	Gainesville	Y	Y	3.5	56	16.00	25	53
8	Miami	Y	Y	2.5	53	21.20	18	38
8	Tampa	N	Y	3.5	47	13.43	25	53
10	Chillicothe	Y	Y	7	68	9.71	49	105
10	Cincinnati	Y	Y	7.5	107	14.27	53	113
10	Cleveland	Y	Y	11.5	142	12.35	81	173
10	Columbus	N	N	2.33	24	10.30	16	35
10	Dayton	N	Y	9	99	11.00	63	135
10	Youngstown	N	Y	3.1	36	11.61	22	47
11	Ann Arbor	Y	Y	3.5	50	14.29	25	53
11	Battle Creek	Y	Y	4	62	15.50	28	60
11	Detroit	Y	Y	7	84	12.00	49	105
11	Northern Indiana	Y	Y	6	74	12.33	42	90
12	Chicago-West Side	Y	Y	5.5	65	11.82	39	83
12	Madison	Y	Y	3.3	45	13.64	23	50
12	Milwaukee	Y	Y	3.5	22	6.29	25	53
12	North Chicago	Y	Y	8.5	111	13.06	60	128
12	Tomah	Y	Y	3.75	45	12.00	26	56
15	St. Louis	N	Y	2.5	46	18.40	18	38
15	Topeka	Y	Y	7.75	100	12.90	54	116
16	Gulf Coast	Y	Y	4.5	42	9.33	32	68
16	Houston	Y	Y	4.5	60	13.33	32	68
16	Little Rock	Y	Y	4	46	11.50	28	60
16	New Orleans	Y	Y	3.5	49	14.00	25	53
17	Dallas	N	Y	6.5	67	10.31	46	98
17	Temple (Waco)	N	Y	4.5	48	10.67	32	68
18	Albuquerque	N	Y	4.5	61	13.56	32	68

TABLE 2-6. CLINICAL STAFF AND CASELOAD

VISN	SITE NAME	*MEDICAL SUPPORT		CLINICAL FTE	9/04 TOTAL # VETS	9/04 CASELOAD per CLIN FTE^	TEAM TARGET CASELOAD	
		MD	RN				MIN	MAX
18	Phoenix	N	Y	5.6	74	13.21	39	84
19	Denver	N	Y	5.5	71	12.91	39	83
19	Grand Junction	N	Y	3.5	39	11.14	25	53
19	Salt Lake City	Y	Y	4.5	52	11.56	32	68
19	Sheridan	Y	Y	1.2	14	11.67	8	18
19	Southern Colorado	N	Y	5.5	80	14.55	39	83
20	American Lake	Y	Y	4	45	11.25	28	60
20	Boise	Y	Y	3	39	13.00	21	45
20	Portland	Y	Y	5.6	68	12.14	39	84
20	Seattle	Y	Y	3.45	50	14.49	24	52
21	Palo Alto	Y	Y	3	36	12.00	21	45
21	San Francisco	Y	Y	3	37	12.33	21	45
22	Greater Los Angeles	N	Y	3.5	51	14.57	25	53
22	San Diego	Y	Y	2.5	43	17.20	18	38
23	Iowa City	Y	Y	4	45	11.25	28	60
23	Knoxville	Y	Y	7	77	11.00	49	105
23	Minneapolis	Y	Y	4.5	64	14.22	32	68
23	Omaha	N	Y	3.5	34	9.71	25	53
23	St. Cloud	Y	Y	3.1	38	12.26	22	47
ALL SITES		69.0%	93.0%	337.59	4209	12.47	2363	5064
SITE AVERAGE				4.75	59.3	12.78	33.5	71.6
SITE STD. DEV				2.07	26.0	3.69	14.5	31.1

* Medical Support assigned to team: N=No, Y=Yes

+ Target Caseload ranges based on client:clinical FTE levels of 7:1 Minimum and 15:1 Maximum

^ Shaded values fall outside minimum standard caseload range (7.0-15.0 clients per clinical FTE) or deviate from expected staffing.

Source: September 2004 FTE/Caseload Report

TABLE 2-7. DEMOGRAPHIC CHARACTERISTICS OF VETERANS AT INTAKE

	OVERALL	GM+S	NP
	(N= 4,761)	(N= 2,779)	(N= 1,982)
	#	#	#
AGE (Mean Years)	50.4	50.0	50.9
GENDER	%	%	%
Male	91.3	90.3	92.8
Female	8.7	9.7	7.2
RACE			
White, non-Hisp.	66.8	62.7	73.2
African-America	26.3	29.3	21.7
Hispanic	3.9	4.4	3.0
Other	1.1	1.3	0.7
Alaskan /American Indian	0.6	0.8	0.4
Asian or Pacific Islander	1.3	1.5	1.0
MARITAL STATUS			
Never Married	45.9	43.7	49.3
Divorced	31.9	31.6	32.3
Married	11.4	13.3	8.5
Separated	6.4	6.4	6.4
Widowed	3.5	3.8	2.9
Living w/signif. other	1.0	1.2	0.6
COMBAT EXPOSURE	21.8	22.4	20.8
EMPLOYMENT LAST 3 YR			
Disability	73.2	74.5	71.2
Hosp./Controlled Environment	3.9	1.8	7.0
Retired	5.3	5.6	4.9
Unemployed	4.3	3.5	5.5
Part-time/Irregular work	5.7	6.1	5.1
Full-time work	4.5	4.8	4.0
Part-time Regular work	2.3	2.7	1.7
Student/Volunteer work	0.8	0.9	0.6

Source: Client Interviews

TABLE 2-8. ENTRY CRITERIA INFORMATION

	OVERALL	GMS	NP
	(N= 4,761)	(N= 2,779)	(N= 1,982)
	#	#	#
MEAN HOSPITAL DAYS (1 Yr Pre)	79.6	56.2	115.7
	%	%	%
INP'T. PSYCH.UNIT REFERRAL	35.9	36.1	35.6
PRIM.PSYCHIATRIC DIAGNOSIS	100.0	100.0	100.0
GTE 30 DAYS IN HOSPITAL	75.1	70.8	81.8
DUAL DIAGNOSIS AT ENTRY	20.9	20.6	21.2
DIAGNOSIS			
Schizophrenia	53.3	53.1	53.7
Schizoaffective	20.4	20.8	19.6
Bipolar Disorder	17.2	17.4	16.9
Affective Disorder	6.6	6.4	6.8
PTSD	8.8	8.9	8.6
Psychosis/Other	3.8	4.2	3.2
Other Disorder	6.5	6.5	6.6
Anxiety Disorder	5.8	4.4	8.0
Alcohol Abuse/Dependence	15.8	14.6	17.7
Organic Brain Syndrome	1.5	1.3	1.8
Dementia	1.6	1.4	1.9
Borderline Personality Disorder	3.2	3.4	3.0
Drug Abuse/Dependence	11.4	12.2	10.1
Adjustment Disorder	0.8	0.9	0.8
DISABILITY/PENSION			
DISABILITY/PENSION	94.1	94.1	94.0
SC DISABILITY	55.4	56.3	53.9
NSC PENSION	18.6	17.7	20.1
SSI	15.1	16.7	12.6
SSDI	49.7	49.5	49.9
PAYEE	46.8	44.0	51.1

Source: Client Interviews

TABLE 2-9. RECEIPT OF DISABILITY COMPENSATION OR PENSION INCOME

VISN SITE	VA COMPENSATION %	NSC PENSION %	SSI %	SSDI %	REP PAYEE %	ANY DISABILITY %
1 Bedford	40.8	18.0	14.0	37.7	28.9	80.8
1 Brockton	48.9	8.7	12.8	46.8	53.2	95.7
1 Togus	80.0	20.8	12.5	36.0	56.0	100.0
1 West Haven	46.4	17.9	17.9	50.0	46.4	100.0
2 Albany	58.3	9.1	14.3	47.8	47.6	87.5
2 Buffalo	50.8	14.5	19.0	48.2	41.0	92.1
2 Canandaigua	54.5	28.3	16.7	52.7	69.1	96.4
2 Syracuse	35.7	12.2	14.6	42.9	29.3	83.3
3 Brooklyn	59.6	14.8	7.1	45.5	15.8	93.0
3 Montrose	64.2	16.7	14.9	55.2	80.6	100.0
3 New Jersey	61.2	18.8	10.7	47.6	50.0	98.8
3 Northport	70.0	8.3	3.6	46.7	26.7	90.0
4 Coatesville	57.6	18.5	21.4	41.7	55.1	98.0
4 Pittsburgh	53.0	28.0	6.8	46.6	26.5	93.3
5 Fayetteville	65.4	8.0	7.7	38.5	48.0	92.3
5 Martinsburg	48.4	11.1	3.4	37.9	19.4	80.6
5 Perry Point	62.6	20.9	12.2	41.8	64.0	96.7
6 Hampton	61.8	28.1	11.8	32.4	35.3	97.1
6 Salem	64.7	6.1	17.6	57.6	44.1	91.2
6 Salisbury	68.6	25.7	5.7	45.7	57.1	100.0
7 Atlanta	90.0	2.9	10.3	65.0	45.0	97.5
7 Augusta	62.0	22.9	8.6	40.0	62.0	98.6
7 Birmingham	50.0	19.0	17.4	45.5	65.2	95.8
7 Tuscaloosa	42.6	10.9	17.0	70.2	73.9	97.9
7 Tuskegee	60.9	12.5	17.8	57.8	60.0	95.7
8 Gainesville	69.4	10.0	14.8	65.6	52.5	100.0
8 Miami	55.6	5.9	22.2	82.4	52.9	100.0
8 Tampa	59.1	40.9	4.5	50.0	40.9	100.0
10 Chillicothe	47.3	20.4	13.0	42.6	45.5	90.9
10 Cincinnati	56.5	7.4	10.7	52.7	31.9	93.9
10 Cleveland	49.4	22.2	18.1	50.6	47.9	95.2
10 Columbus	53.8	25.0	16.0	64.0	48.0	96.2
10 Dayton	50.5	23.2	23.5	41.9	31.4	92.5
10 Youngstown	40.9	17.1	42.9	39.5	51.2	86.4
11 Ann Arbor	61.1	9.8	11.3	64.8	53.7	94.4
11 Battle Creek	46.4	20.9	19.1	66.2	51.5	97.1
11 Detroit	66.3	22.7	21.6	59.8	46.1	96.6
11 Northern Indiana	56.1	12.2	22.0	53.7	56.1	97.6
12 Chicago-West Side	42.6	10.4	22.4	42.0	24.0	96.3
12 Madison	47.9	21.3	14.9	64.6	52.1	93.8
12 Milwaukee	66.7	22.6	18.2	36.4	42.4	100.0
12 North Chicago	43.0	19.3	20.4	50.0	59.8	96.5
12 Tomah	52.4	21.1	15.0	65.0	52.4	95.2
15 St. Louis	40.4	28.6	18.0	43.1	46.0	84.6
15 Topeka	40.0	15.8	7.9	52.6	42.5	80.0
16 Gulf Coast	50.0	25.0	11.9	55.2	26.7	95.0
16 Houston	42.2	14.8	35.9	39.7	47.6	96.9
16 Little Rock	53.3	26.2	13.3	37.8	71.1	100.0
16 New Orleans	69.6	11.5	14.5	50.0	42.6	98.2

VISN SITE	VA COMPENSATION %	NSC PENSION %	SSI %	SSDI %	REP PAYEE %	ANY DISABILITY %
17 Dallas	53.4	21.9	11.1	43.7	46.6	90.4
17 Temple (Waco)	50.0	17.5	7.9	42.9	46.9	93.8
18 Albuquerque	57.1	13.3	12.7	60.3	38.1	95.2
18 Phoenix	62.2	20.3	19.2	45.2	43.8	94.6
19 Denver	71.2	19.4	15.5	43.8	53.4	97.3
19 Grand Junction	36.2	17.0	12.8	48.9	25.5	83.0
19 Salt Lake City	74.1	9.4	11.1	68.5	74.1	98.1
19 Sheridan	52.9	28.6	6.7	81.3	26.7	94.1
19 Southern Colorado	73.7	24.2	7.5	46.8	65.3	98.9
20 American Lake	59.2	14.6	6.1	62.5	43.8	91.8
20 Boise	68.3	40.0	30.8	58.5	56.4	100.0
20 Portland	46.4	21.4	14.3	49.1	39.3	89.3
20 Seattle	49.1	26.4	10.7	37.5	45.6	94.7
21 Palo Alto	58.1	7.1	39.0	40.0	74.4	97.7
21 San Francisco	55.3	17.8	26.1	48.9	44.7	97.9
22 Greater Los Angeles	64.6	9.3	24.4	48.9	56.5	87.5
22 San Diego	56.3	13.5	21.7	35.6	32.6	83.3
23 Iowa City	59.2	10.4	12.5	49.0	30.6	89.8
23 Knoxville	47.8	33.3	2.2	56.7	43.8	88.9
23 Minneapolis	56.3	18.6	13.0	62.9	41.4	97.2
23 Omaha	59.0	16.7	5.1	48.7	53.8	92.3
23 St. Cloud	54.1	16.7	16.2	59.5	43.2	97.3
ALL SITES	55.4	18.6	15.1	49.7	46.8	94.1
SITE AVERAGE	56.1	17.9	15.1	50.5	47.1	94.1
SITE STD. DEV.	10.5	7.7	7.7	10.7	13.8	5.2

Source: Client Interview

TABLE 2-10. ENTRY CRITERIA INFORMATION BY SITE

VISN	SITE	LIFETIME HOSP GT 2 YRS	YEARS SINCE 1ST HOSP.	GTE 30 DAYS HOSP. YR PREV	PSYCHOTIC DX AT ENTRY	DUAL DIAGNOSIS
		%	#	%	%	%
1	Bedford	30.1	19.4	69.0	64.6	54.6
1	Brockton	62.2	23.4	87.2	93.6	19.1
1	Togus	40.9	27.8	92.0	92.0	0.0
1	West Haven	51.9	20.8	92.9	85.7	21.4
2	Albany	34.8	19.5	58.3	87.5	54.2
2	Buffalo	19.2	26.8	25.9	76.2	27.0
2	Canandaigua	67.9	24.0	85.2	94.5	34.5
2	Syracuse	24.4	16.6	84.6	66.7	19.0
3	Brooklyn	38.2	23.8	84.2	80.7	14.0
3	Montrose	84.5	27.7	91.0	98.5	10.4
3	New Jersey	45.8	25.1	69.0	91.8	29.4
3	Northport	39.3	25.6	96.7	83.3	6.7
4	Coatesville	58.4	24.1	89.7	88.9	27.3
4	Pittsburgh	40.2	23.1	89.1	94.0	8.2
5	Martinsburg	17.9	15.5	64.5	61.3	32.3
5	Perry Point	84.7	31.9	100.0	96.7	8.8
6	Fayetteville	40.0	18.2	48.0	80.8	15.4
6	Hampton	48.5	23.9	76.5	82.4	35.3
6	Salem	50.0	22.2	65.6	82.4	47.1
6	Salisbury	58.8	24.4	85.7	97.1	25.7
7	Atlanta	52.6	21.4	97.5	87.5	2.5
7	Augusta	80.0	23.1	98.6	94.4	4.2
7	Birmingham	54.5	25.7	95.5	91.7	20.8
7	Tuscaloosa	73.9	26.1	97.8	95.7	17.0
7	Tuskegee	26.7	23.3	66.7	87.0	6.5
8	Gainesville	45.6	22.4	72.6	93.5	6.5
8	Miami	41.2	25.4	53.3	94.4	5.6
8	Tampa	38.1	22.7	61.9	95.5	9.1
10	Chillicothe	57.7	19.8	85.5	83.6	14.5
10	Cincinnati	20.4	21.7	47.6	87.0	15.7
10	Cleveland	41.9	23.9	83.5	94.0	19.0
10	Columbus	28.0	16.6	72.0	96.2	7.7
10	Dayton	23.0	22.0	39.6	84.1	14.0
10	Youngstown	21.6	23.1	45.2	90.9	18.2
11	Ann Arbor	28.3	19.5	73.6	98.1	27.8
11	Battle Creek	66.7	24.1	88.4	88.4	11.6
11	Detroit	60.0	23.7	92.0	97.8	21.3
11	Northern Indiana	66.7	27.9	100.0	90.2	24.4
12	Chicago-West Side	29.6	22.0	92.0	87.0	9.3
12	Madison	36.2	22.2	72.3	95.8	18.8
12	Milwaukee	33.3	22.9	30.0	97.0	15.2
12	North Chicago	60.0	25.0	73.5	87.7	19.3

VISN	SITE	LIFETIME	YEARS SINCE	GTE 30 DAYS	PSYCHOTIC DX	DUAL
		HOSP GT 2 YRS	1ST HOSP.	HOSP. YR PREV	AT ENTRY	DIAGNOSIS
		%	#	%	%	%
12	Tomah	66.7	29.4	68.4	95.2	42.9
15	St. Louis	27.7	23.5	60.9	76.9	38.5
15	Topeka	48.6	17.7	89.7	85.0	32.5
16	Gulf Coast	29.3	21.7	85.0	80.0	30.0
16	Houston	28.6	23.2	47.6	92.2	32.8
16	Little Rock	27.8	24.8	82.2	93.3	4.4
16	New Orleans	41.3	23.9	62.5	100.0	8.9
17	Dallas	28.4	18.3	87.7	93.2	21.9
17	Temple (Waco)	60.0	19.7	79.4	90.6	12.5
18	Albuquerque	41.9	22.1	66.7	95.2	6.3
18	Phoenix	31.4	27.4	51.5	81.1	16.2
19	Denver	41.2	21.8	94.5	94.5	30.1
19	Grand Junction	21.3	20.3	51.1	87.2	34.0
19	Salt Lake City	38.8	22.3	42.6	94.4	29.6
19	Sheridan	41.2	24.1	100.0	76.5	58.8
19	Southern Colorado	57.6	27.4	22.3	89.5	10.5
20	American Lake	31.9	19.0	95.8	100.0	22.4
20	Boise	21.6	19.6	45.0	97.6	22.0
20	Portland	28.6	21.9	98.2	94.6	25.0
20	Seattle	30.8	25.6	42.9	86.0	28.1
21	Palo Alto	76.7	24.5	97.7	100.0	37.2
21	San Francisco	34.8	22.2	85.1	91.5	25.5
22	Greater Los Angeles	61.7	21.3	97.9	87.5	27.1
22	San Diego	25.5	20.3	95.7	77.1	29.2
23	Iowa City	23.4	26.5	68.8	81.6	14.3
23	Knoxville	39.5	21.8	94.4	80.0	17.8
23	Minneapolis	52.9	22.7	97.1	98.6	5.6
23	Omaha	33.3	22.3	59.5	84.6	25.6
23	St. Cloud	47.1	24.8	56.8	86.5	45.9
ALL SITES		43.6	23.1	75.1	88.9	20.9
SITE AVERAGE		43.1	22.9	74.9	88.8	21.6
SITE STD. DEV.		16.9	3.1	20.5	8.2	13.1

^ Shaded values do not meet the minimum standard (50% with 30+ hospital days in year prior to entry.)
Source: Client Interview

TABLE 2-11. CLINICAL STATUS AT ENTRY

VISN	SITE	INPATIENT AT ENTRY %	LOW IADL %	BPRS MEAN #	GAF MEAN #
1	Bedford	33.1	41.9	37.7	40.8
1	Brockton	6.4	44.4	36.3	31.6
1	Togus	64.0	32.0	34.2	42.2
1	West Haven	89.3	46.4	39.8	32.1
2	Albany	4.2	41.7	50.5	36.8
2	Buffalo	4.9	64.4	42.6	36.0
2	Canandaigua	7.3	39.6	40.6	34.0
2	Syracuse	34.1	63.4	43.4	41.0
3	Brooklyn	40.4	50.0	41.5	41.0
3	Montrose	68.7	69.4	46.6	39.7
3	New Jersey	50.6	56.8	39.8	43.5
3	Northport	43.3	62.1	43.0	44.2
4	Coatesville	32.3	68.0	42.8	39.4
4	Pittsburgh	45.9	42.6	34.8	38.3
5	Martinsburg	3.4	35.5	35.3	44.9
5	Perry Point	56.0	63.4	46.2	39.3
6	Fayetteville	7.7	44.0	43.9	46.2
6	Hampton	8.8	52.9	43.4	39.9
6	Salem	2.9	35.5	37.0	46.3
6	Salisbury	42.9	54.5	48.1	39.3
7	Atlanta	80.0	55.0	35.1	45.6
7	Augusta	64.8	44.6	30.7	43.1
7	Birmingham	8.7	50.0	39.2	45.2
7	Tuscaloosa	27.7	66.7	28.2	42.6
7	Tuskegee	63.0	60.9	38.1	48.0
8	Gainesville	40.3	56.7	48.6	42.2
8	Miami	41.2	61.1	36.7	35.0
8	Tampa	22.7	50.0	43.7	47.5
10	Chillicothe	67.3	31.5	34.2	39.8
10	Cincinnati	23.7	48.7	38.2	45.0
10	Cleveland	39.9	49.4	37.2	36.6
10	Columbus	20.0	50.0	35.5	45.9
10	Dayton	15.9	35.8	37.8	46.4
10	Youngstown	4.5	55.8	39.4	47.8
11	Ann Arbor	33.3	56.3	42.9	35.9
11	Battle Creek	15.9	59.1	37.3	47.3
11	Detroit	65.9	52.4	33.5	43.6
11	Northern Indiana	78.0	53.8	39.9	46.5
12	Chicago-West Side	44.4	50.0	39.4	36.7
12	Madison	46.8	46.8	36.9	43.7
12	Milwaukee	0.0	66.7	53.8	42.8
12	North Chicago	43.0	43.7	33.6	34.0
12	Tomah	0.0	38.1	44.3	37.9
15	St. Louis	38.5	57.4	62.6	40.4
15	Topeka	50.0	56.8	45.1	39.7
16	Gulf Coast	15.0	50.0	37.2	48.2
16	Houston	23.4	59.4	42.0	40.2
16	Little Rock	13.3	65.0	38.2	25.4
16	New Orleans	49.1	56.9	47.8	35.7
17	Dallas	82.2	58.9	36.9	39.3

VISN	SITE	INPATIENT AT ENTRY %	LOW IADL %	BPRS MEAN #	GAF MEAN #
17	Temple (Waco)	25.0	41.3	43.8	39.0
18	Albuquerque	41.3	24.2	35.5	38.1
18	Phoenix	22.2	36.7	47.0	47.0
19	Denver	67.1	50.0	36.5	37.3
19	Grand Junction	59.6	53.2	58.2	35.0
19	Salt Lake City	25.9	51.9	54.3	33.7
19	Sheridan	46.7	41.2	53.1	48.8
19	Southern Colorado	4.2	46.4	32.8	42.8
20	American Lake	16.3	54.2	46.4	38.6
20	Boise	5.0	48.8	37.2	40.0
20	Portland	50.0	69.8	39.0	30.0
20	Seattle	8.8	63.2	54.4	38.4
21	Palo Alto	11.6	86.0	47.8	39.4
21	San Francisco	27.7	58.7	44.2	37.4
22	Greater Los Angeles	62.5	60.4	46.0	46.2
22	San Diego	0.0	41.7	44.0	37.4
23	Iowa City	65.3	59.6	39.7	28.2
23	Knoxville	10.0	61.8	37.8	35.0
23	Minneapolis	73.9	34.3	45.8	34.6
23	Omaha	30.8	59.0	36.2	35.1
23	St. Cloud	27.0	40.6	45.6	43.1
	ALL SITES	35.9	51.5	40.6	39.9
	SITE AVERAGE	34.4	51.8	41.5	40.1
	SITE STD. DEV.	24.1	11.0	6.5	5.1
	Shaded values are greater than or equal to 50..				
	Source: Client Interview				

TABLE 2-12. MHICM PROGRAM TENURE

VISN	SITE	TOTAL VETS FY02	VETS DISCHARGED #	VETS DISCHARGED %	MEAN DAYS IN PROGRAM PER VET
1	Bedford	130	23	17.7%	1,513
1	Brockton	79	11	13.9%	1,737
1	Togus	27	3	11.1%	1,835
1	West Haven	62	7	11.3%	1,623
2	Albany	49	4	<u>8.2%</u>	885
2	Buffalo	83	6	<u>7.2%</u>	1,263
2	Canandaigua	101	12	11.9%	1,697
2	Syracuse	53	10	18.9%	1,372
3	Brooklyn	58	13	22.4%	1,671
3	Montrose	102	16	15.7%	1,733
3	New Jersey	89	13	14.6%	1,466
3	Northport	103	15	14.6%	456
4	Coatesville	101	16	15.8%	1,831
4	Pittsburgh	136	21	15.4%	1,475
5	Martinsburg	33	10	30.3%	255
5	Perry Point	91	28	30.8%	1,901
6	Fayetteville	27	2	<u>7.4%</u>	535
6	Hampton	59	14	23.7%	467
6	Salem	44	12	27.3%	471
6	Salisbury	38	9	23.7%	1,337
7	Atlanta	61	17	27.9%	2,045
7	Augusta	71	3	<u>4.2%</u>	2,104
7	Birmingham	25	3	12.0%	400
7	Tuscaloosa	69	10	14.5%	459
7	Tuskegee	52	6	11.5%	1,589
8	Gainesville	62	6	9.7%	2,185
8	Miami	53	1	<u>1.9%</u>	554
8	Tampa	52	9	17.3%	341
10	Chillicothe	73	7	9.6%	1,889
10	Cincinnati	116	14	12.1%	836
10	Cleveland	169	29	17.2%	1,100
10	Columbus	27	4	14.8%	1,213
10	Dayton	110	11	10.0%	713
10	Youngstown	45	8	17.8%	858
11	Ann Arbor	54	4	<u>7.4%</u>	1,929
11	Battle Creek	72	13	18.1%	1,540
11	Detroit	94	14	14.9%	1,503
11	Northern Indiana	82	14	17.1%	434
12	Chicago-West Side	70	8	11.4%	1,203
12	Madison	49	5	10.2%	1,700
12	Milwaukee	33	8	24.2%	700
12	North Chicago	118	13	11.0%	1,672
12	Tomah	48	9	18.8%	416
15	St. Louis	54	11	20.4%	309
15	Topeka	112	17	15.2%	397
16	Gulf Coast	61	22	36.1%	580
16	Houston	64	7	10.9%	892
16	Little Rock	49	6	12.2%	730
16	New Orleans	58	11	19.0%	577

VISN	SITE	TOTAL VETS FY02	VETS DISCHARGED #	VETS DISCHARGED %	MEAN DAYS IN PROGRAM PER VET
17	Dallas	73	8	11.0%	1,837
17	Temple (Waco)	65	21	32.3%	2,156
18	Albuquerque	64	2	3.1%	352
18	Phoenix	84	18	21.4%	415
19	Denver	74	6	8.1%	1,648
19	Grand Junction	48	10	20.8%	1,060
19	Salt Lake City	56	7	12.5%	1,075
19	Sheridan	18	4	22.2%	953
19	Southern Colorado	97	18	18.6%	1,315
20	American Lake	51	8	15.7%	2,200
20	Boise	42	4	9.5%	2,142
20	Portland	78	18	23.1%	1,128
20	Seattle	58	9	15.5%	1,300
21	Palo Alto	45	11	24.4%	638
21	San Francisco	48	11	22.9%	1,640
22	Greater Los Angeles	51	2	3.9%	2,178
22	San Diego	48	8	16.7%	264
23	Iowa City	50	9	18.0%	474
23	Knoxville	90	20	22.2%	949
23	Minneapolis	72	9	12.5%	1,981
23	Omaha	42	6	14.3%	309
23	St. Cloud	39	5	12.8%	672
ALL SITES		4,761	749	15.7 %	1,301
SITE AVERAGE		67.1	11	15.9 %	1,170
SITE STD. DEV.		28.8	6	7.0 %	615

^Shaded values exceed the threshold level (20%) for the minimum program standard.

Source: Clinical Progrss Reports as of 9/30/02

TABLE 2-13. PATTERN OF SERVICE DELIVERY

VISN	SITE	Total VETS #	CONTACT FREQUENCY % WEEKLY OR MORE		INTENSITY 1 OR MORE HRS / WEEK CONTACT	LOCATION 60% OR MORE CONTACT IN COMMUNITY
			FACE-FACE	TELEPHONE		
1	Bedford	130	91.5	60.8	60.8	74.6
1	Brockton	79	83.5	32.9	57.0	84.8
1	Togus	27	92.6	55.6	77.8	92.6
1	West Haven	62	91.9	66.1	59.7	83.9
2	Albany	49	79.6	44.9	63.3	71.4
2	Buffalo	83	86.7	44.6	55.4	91.6
2	Canandaigua	101	82.2	30.7	80.2	71.3
2	Syracuse	53	60.4	43.4	47.2	45.3
3	Brooklyn	58	74.1	69.0	60.3	79.3
3	Montrose	102	88.2	13.7	15.7	89.2
3	New Jersey	89	84.3	51.7	58.4	91.0
3	Northport	103	94.2	45.6	64.1	91.3
4	Coatesville	101	77.2	44.6	54.5	65.3
4	Pittsburgh	136	83.8	53.7	35.3	83.1
5	Martinsburg	33	93.9	69.7	57.6	84.8
5	Perry Point	91	96.7	17.6	82.4	95.6
6	Fayetteville	27	96.3	63.0	48.1	88.9
6	Hampton	59	94.9	59.3	66.1	78.0
6	Salem	44	79.5	38.6	59.1	86.4
6	Salisbury	38	92.1	60.5	89.5	100.0
7	Atlanta	61	86.9	75.4	62.3	82.0
7	Augusta	71	73.2	25.4	76.1	83.1
7	Birmingham	25	92.0	84.0	76.0	92.0
7	Tuscaloosa	69	95.7	56.5	69.6	94.2
7	Tuskegee	52	92.3	53.8	69.2	96.2
8	Gainesville	62	88.7	69.4	75.8	96.8
8	Miami	53	94.3	77.4	84.9	100.0
8	Tampa	52	75.0	36.5	32.7	96.2
10	Chillicothe	73	100.0	71.2	75.3	100.0
10	Cincinnati	116	97.4	73.3	47.4	94.8
10	Cleveland	169	97.6	60.9	55.6	97.6
10	Columbus	27	70.4	44.4	59.3	88.9
10	Dayton	110	89.1	76.4	67.3	98.2
10	Youngstown	45	93.3	68.9	42.2	93.3
11	Ann Arbor	54	61.1	48.1	51.9	85.2
11	Battle Creek	72	91.7	50.0	38.9	98.6
11	Detroit	94	53.2	26.6	36.2	89.4
11	Northern Indiana	82	97.6	26.8	63.4	92.7
12	Chicago-West Side	70	95.7	61.4	85.7	94.3
12	Madison	49	91.8	36.7	59.2	77.6
12	Milwaukee	33	93.9	66.7	78.8	93.9
12	North Chicago	118	89.0	26.3	72.0	90.7
12	Tomah	48	81.3	70.8	77.1	70.8
15	St. Louis	54	83.3	68.5	59.3	88.9
15	Topeka	112	97.3	56.3	68.8	84.8
16	Gulf Coast	61	83.6	45.9	59.0	88.5
16	Houston	64	93.8	34.4	82.8	89.1
16	Little Rock	49	98.0	49.0	65.3	95.9

VISN	SITE	Total VETS #	CONTACT FREQUENCY % WEEKLY OR MORE		INTENSITY 1 OR MORE HRS / WEEK	LOCATION 60% OR MORE CONTACT IN COMMUNITY
			FACE-FACE	TELEPHONE	CONTACT	
16	New Orleans	58	84.5	46.6	67.2	94.8
17	Dallas	73	90.4	43.8	30.1	91.8
17	Temple (Waco)	65	100.0	90.8	<u>86.2</u>	95.4
18	Albuquerque	64	98.4	93.8	<u>96.9</u>	96.9
18	Phoenix	84	85.7	82.1	78.6	94.0
19	Denver	74	94.6	47.3	59.5	90.5
19	Grand Junction	48	81.3	75.0	75.0	77.1
19	Salt Lake City	56	98.2	39.3	75.0	89.3
19	Sheridan	18	77.8	61.1	<u>83.3</u>	<u>100.0</u>
19	Southern Colorado	97	94.8	51.5	63.9	<u>99.0</u>
20	American Lake	51	94.1	51.0	56.9	94.1
20	Boise	42	73.8	50.0	66.7	90.5
20	Portland	78	80.8	41.0	69.2	88.5
20	Seattle	58	77.6	69.0	65.5	89.7
21	Palo Alto	45	91.1	60.0	<u>82.2</u>	95.6
21	San Francisco	48	97.9	22.9	22.9	85.4
22	Greater Los Angeles	51	74.5	66.7	68.6	92.2
22	San Diego	48	97.9	79.2	77.1	95.8
23	Iowa City	50	86.0	66.0	38.0	96.0
23	Knoxville	90	97.8	50.0	40.0	98.9
23	Minneapolis	72	87.5	55.6	59.7	<u>100.0</u>
23	Omaha	42	90.5	45.2	47.6	97.6
23	St. Cloud	39	94.9	61.5	59.0	94.9
ALL SITES		4761	88.2	52.8	61.4	89.3
SITE AVERAGE		67.1	87.8	54.3	62.7	89.4
SITE STD. DEV.		28.8	9.9	17.4	16.3	9.5

~Shaded values do not meet the minimum standard of 50% or more contact in community.

Bold /Underlined values represent positive outliers.

Source: Clinical Progress Reports as of 9/30/04

TABLE 2-14. OUTPATIENT CLINIC VISITS

VISN	SITE	TOTAL VETS SEEN	MEAN CONTACTS per VET:12 MONTH			FY 2004 MEAN AMOUNT OF TIME IN PGM	ADJUSTED FACE-FACE CONTACTS/ VETERAN	ADJUSTED FACE-FACE CONTACTS/ WK/VETERAN^
			TOTAL	TELEPHONE	FACE:FACE			
1	Bedford	128	104.32	9.46	94.86	0.87	108.7	<u>2.09</u>
1	Brockton	79	41.78	3.67	38.11	0.84	45.3	0.87
1	Togus	27	57.85	8.89	48.96	0.88	55.7	1.07
1	West Haven	61	93.41	22.46	70.95	0.89	80.0	1.54
2	Albany	48	92.19	4.42	87.77	0.90	97.7	<u>1.88</u>
2	Buffalo	81	41.59	3.06	38.53	0.79	48.9	0.94
2	Canandaigua	94	81.87	2.49	79.38	0.89	88.8	1.71
2	Syracuse	52	37.23	4.04	33.19	0.82	40.4	0.78
3	Brooklyn	55	38.31	9.33	28.98	0.78	37.3	0.72
3	Montrose	96	56.30	2.84	53.40	0.90	59.1	1.14
3	New Jersey	85	48.06	4.42	41.93	0.84	49.9	0.96
3	Northport	100	57.42	2.71	54.52	0.88	61.9	1.19
4	Coatesville	96	54.92	2.88	49.16	0.80	61.5	1.18
4	Pittsburgh	133	36.09	1.19	34.90	0.86	40.7	0.78
5	Martinsburg	31	37.68	6.68	31.00	0.60	51.7	0.99
5	Perry Point	88	43.59	0.07	43.52	0.83	52.4	1.01
6	Fayetteville	26	72.31	4.58	67.73	0.84	81.1	1.56
6	Hampton	57	67.84	1.95	65.88	0.73	90.7	1.74
6	Salem	42	40.21	2.98	37.02	0.78	47.6	0.92
6	Salisbury	37	54.35	1.35	50.73	0.71	71.7	1.38
7	Atlanta	57	76.33	4.70	71.63	0.82	87.3	1.68
7	Augusta	69	51.90	0.70	51.20	0.97	53.1	1.02
7	Birmingham	25	77.52	0.04	77.48	0.74	105.3	<u>2.03</u>
7	Tuscaloosa	67	75.43	2.30	73.13	0.87	83.8	1.61
7	Tuskegee	50	63.28	0.82	62.46	0.83	75.1	1.44
8	Gainesville	60	70.22	5.32	64.90	0.91	71.4	1.37
8	Miami	52	75.48	4.29	71.19	0.93	76.2	1.47
8	Tampa	52	56.17	6.79	49.38	0.85	58.1	1.12
10	Chillicothe	70	55.87	1.17	54.70	0.87	62.7	1.21
10	Cincinnati	115	44.70	1.23	43.47	0.81	53.8	1.04
10	Cleveland	166	59.62	0.05	59.45	0.76	77.9	1.50
10	Columbus	27	43.07	4.93	38.15	0.76	50.4	0.97
10	Dayton	107	41.79	0.00	41.79	0.71	59.2	1.14
10	Youngstown	44	66.02	0.00	66.02	0.84	78.5	1.51
11	Ann Arbor	53	75.51	2.58	72.92	0.88	82.5	1.59
11	Battle Creek	70	54.10	0.10	53.17	0.87	60.9	1.17
11	Detroit	94	32.00	0.01	31.97	0.90	35.7	0.69
11	Northern Indiana	81	67.59	0.00	67.51	0.78	86.6	1.67
12	Chicago-West Side	63	65.59	1.56	64.03	0.87	73.3	1.41
12	Madison	48	133.75	0.00	133.75	0.88	151.7	<u>2.92</u>
12	Milwaukee	31	66.03	1.10	64.94	0.76	85.6	1.65
12	North Chicago	117	105.32	0.39	104.93	0.93	112.6	<u>2.17</u>
12	Tomah	46	117.15	4.74	112.41	0.80	141.0	<u>2.71</u>
15	St. Louis	52	69.00	16.38	52.62	0.77	68.3	1.31
15	Topeka	108	119.63	4.34	115.29	0.85	135.2	<u>2.60</u>
16	Gulf Coast	58	53.81	8.07	45.69	0.74	61.6	1.19
16	Houston	63	44.16	0.98	43.17	0.89	48.8	0.94
16	Little Rock	48	83.94	5.60	72.75	0.87	83.5	1.61
16	New Orleans	57	36.74	1.72	35.02	0.81	43.1	0.83
17	Dallas	71	73.28	0.25	73.03	0.91	79.9	1.54
17	Temple (Waco)	47	75.15	0.04	75.11	0.84	89.9	1.73
18	Albuquerque	62	105.40	26.90	78.50	0.69	113.5	<u>2.18</u>

VISN	SITE	TOTAL VETS SEEN	MEAN CONTACTS per VET:12 MONTH			FY 2004 MEAN AMOUNT OF TIME IN PGM	ADJUSTED	ADJUSTED
			TOTAL	TELEPHONE	FACE:FACE		FACE-FACE CONTACTS/ VETERAN	FACE-FACE CONTACTS/ WK/VETERAN^
18	Phoenix	80	31.34	1.14	30.20	0.77	39.2	0.75
19	Denver	74	49.99	0.03	49.96	0.92	54.4	1.05
19	Grand Junction	48	62.58	6.44	56.15	0.80	70.4	1.35
19	Salt Lake City	54	46.89	0.19	46.63	0.88	53.2	1.02
19	Sheridan	17	39.12	1.29	37.82	0.88	43.2	0.83
19	Southern Colorado	90	54.22	1.88	52.34	0.83	63.3	1.22
20	American Lake	50	49.16	0.44	48.70	0.85	57.5	1.11
20	Boise	40	24.13	0.05	24.08	0.87	27.7	0.53
20	Portland	76	64.74	4.20	60.28	0.76	79.4	1.53
20	Seattle	56	52.09	2.20	49.54	0.71	69.8	1.34
21	Palo Alto	45	42.89	2.04	40.84	0.84	48.4	0.93
21	San Francisco	46	52.80	0.17	52.63	0.79	66.3	1.28
22	Greater Los Angeles	48	21.27	0.00	21.27	0.94	22.6	0.43
22	San Diego	47	55.91	5.30	50.62	0.64	79.2	1.52
23	Iowa City	42	40.07	0.00	40.07	0.80	50.2	0.97
23	Knoxville	89	53.74	3.94	49.80	0.84	59.4	1.14
23	Minneapolis	68	48.66	1.54	47.07	0.91	51.8	1.00
23	Omaha	39	58.33	0.92	57.41	0.74	77.4	1.49
23	St. Cloud	38	39.16	0.00	38.68	0.89	43.7	0.84
ALL SITES		4593	61.03	3.18	57.64	0.83	69.2	1.33
SITE AVERAGE		64.69	60.28	3.36	56.71	0.83	68.66	1.32
SITE STD. DEV.		28.04	22.50	4.69	21.35	0.07	25.01	0.48

^Shaded values do not meet the minimum standard of at least 1 face-to-face contact per client per week.

Bold /Underlined values exceed one standard deviation from the mean in desired direction.

Source: Outpatient clinic visits entered under DSS Identifiers 546 and 552 between 10/01/03 and 9/30/04.

*Corrected outpatient clinic visit totals provided by facility.

TABLE 2-15A. THERAPEUTIC SERVICES

VISN	SITE	FOLLOW- UP VETS #	SUPPORTIVE CONTACT %	ACTIVE MONITOR %	REHABIL- ITATION %	PSYCHOTHER. RELATIONSHIP %	SOCIAL/REC. ACTIVITIES %	CRISIS INTERVENT %
1	Bedford	130	100.0	95.4	58.7	98.2	76.1	77.1
1	Brockton	79	97.1	95.6	38.8	92.6	54.4	39.7
1	Togus	27	95.8	95.8	70.8	95.8	50.0	12.5
1	West Haven	62	100.0	98.1	69.2	94.2	65.4	73.1
2	Albany	49	94.1	97.1	64.7	94.1	64.7	55.9
2	Buffalo	83	98.1	98.0	7.8	61.5	25.0	48.1
2	Canandaigua	101	93.1	92.0	71.3	83.9	85.1	34.5
2	Syracuse	53	92.5	95.0	77.5	20.0	40.0	70.0
3	Brooklyn	58	89.7	90.0	50.0	60.0	32.5	70.0
3	Montrose	102	87.8	92.0	39.6	51.6	61.5	67.0
3	New Jersey	89	95.7	95.7	43.5	92.9	70.0	62.9
3	Northport	103	86.4	97.7	30.7	97.7	50.0	61.4
4	Coatesville	101	94.9	93.8	25.9	72.8	55.6	74.1
4	Pittsburgh	136	97.2	99.1	33.3	88.0	8.3	40.7
5	Martinsburg	33	100.0	93.8	68.8	62.5	56.3	81.3
5	Perry Point	91	100.0	100.0	73.6	78.0	93.4	64.8
6	Fayetteville	27	95.7	100.0	21.7	87.0	87.0	82.6
6	Hampton	59	95.6	97.8	50.0	100.0	50.0	93.5
6	Salem	44	96.7	93.3	23.3	96.7	13.3	93.3
6	Salisbury	38	100.0	100.0	80.0	76.7	90.0	86.7
7	Atlanta	61	96.4	83.3	30.0	53.3	20.0	70.0
7	Augusta	71	91.7	93.3	80.0	88.3	80.0	75.0
7	Birmingham	25	94.7	94.7	36.8	94.7	100.0	94.7
7	Tuscaloosa	69	95.6	97.8	28.3	87.0	73.9	67.4
7	Tuskegee	52	96.4	96.4	92.9	78.6	85.7	89.3
8	Gainesville	62	100.0	94.7	54.4	98.2	91.1	78.9
8	Miami	53	100.0	100.0	39.4	100.0	100.0	93.9
8	Tampa	52	100.0	95.7	25.5	93.6	29.8	57.4
10	Chillicothe	73	100.0	100.0	64.4	93.6	84.8	51.1
10	Cincinnati	116	93.0	98.8	75.0	67.9	61.9	76.2
10	Cleveland	169	96.2	98.1	41.5	87.7	50.0	62.3
10	Columbus	27	100.0	100.0	66.7	66.7	76.2	81.0
10	Dayton	110	100.0	98.4	42.6	98.4	77.0	80.3
10	Youngstown	45	88.6	100.0	66.7	91.7	91.7	69.4
11	Ann Arbor	54	97.8	97.8	50.0	84.8	95.7	56.5
11	Battle Creek	72	100.0	100.0	78.9	98.2	96.5	87.7
11	Detroit	94	96.5	98.8	11.6	85.9	39.5	80.2
11	Northern Indiana	82	100.0	98.5	72.7	90.9	78.8	51.5
12	Chicago-West Side	70	89.7	93.3	93.3	86.7	13.3	40.0
12	Madison	49	93.0	97.7	32.6	97.7	83.7	76.7
12	Milwaukee	33	100.0	86.7	50.0	87.5	75.0	81.3
12	North Chicago	118	99.1	95.4	51.9	75.9	82.6	57.8
12	Tomah	48	91.7	89.2	16.2	62.2	83.8	54.1
15	St. Louis	54	86.1	80.0	30.3	65.7	61.8	58.8
15	Topeka	112	100.0	96.3	39.5	61.3	75.3	81.5
16	Gulf Coast	61	92.3	90.4	42.3	90.4	61.5	65.4
16	Houston	64	94.8	93.1	32.8	81.0	64.9	82.8
16	Little Rock	49	100.0	100.0	53.7	100.0	82.9	82.9
16	New Orleans	58	97.1	100.0	40.0	77.1	80.0	74.3
17	Dallas	73	97.1	95.7	50.7	76.8	31.9	76.8

VISN	SITE	FOLLOW- UP VETS #	SUPPORTIVE CONTACT %	ACTIVE MONITOR %	REHABIL- ITATION %	PSYCHOTHER. RELATIONSHIP %	SOCIAL/REC. ACTIVITIES %	CRISIS INTERVENT %
17	Temple (Waco)	65	100.0	100.0		100.0	56.3	46.9
18	Albuquerque	64	97.6	95.0	70.7	85.4	92.7	92.7
18	Phoenix	84	87.9	88.2	23.5	58.8	58.8	67.6
19	Denver	74	100.0	97.0	49.3	97.0	64.2	59.7
19	Grand Junction	48	100.0	92.1	52.6	89.5	68.4	57.9
19	Salt Lake City	56	100.0	97.8	37.0	60.9	73.9	80.4
19	Sheridan	18	100.0	80.0	<u>80.0</u>	73.3		80.0
19	Southern Colorado	97	98.2	91.2	49.1	52.6	80.7	82.5
20	American Lake	51	100.0	97.9	70.2	95.7	95.7	59.6
20	Boise	42	97.1	91.2	43.8	87.9	78.8	78.8
20	Portland	78	98.5	98.5	47.7	52.3	43.1	58.5
20	Seattle	58	100.0	88.0	20.0	52.0	56.0	72.0
21	Palo Alto	45	96.8	96.9	<u>81.3</u>	96.9	84.4	81.3
21	San Francisco	48	100.0	100.0	<u>83.7</u>	79.1	34.9	72.1
22	Greater Los Angeles	51	100.0	100.0	45.2	96.8	93.5	96.8
22	San Diego	48	100.0	100.0	<u>84.8</u>	97.0	97.0	90.9
23	Iowa City	50	97.7	93.2	47.7	86.4	34.1	70.5
23	Knoxville	90	98.9	98.9	32.6	93.3	53.9	69.7
23	Minneapolis	72	100.0	90.2	58.5	100.0	17.1	53.7
23	Omaha	42	97.1	94.1	55.9	82.4	73.5	61.8
23	St. Cloud	39	100.0	95.7	34.8	91.3	21.7	47.8
ALL SITES		4761	96.6	95.9	49.1	82.6	63.6	67.8
SITE AVERAGE		67.1	96.7	95.4	50.8	82.5	64.8	69.4
SITE STD. DEV.		28.8	3.8	4.6	20.7	16.4	24.4	16.3

Shaded values do not meet the threshold level (25%) for the minimum standard. Bold/Underlined values represent positive outliers.

Source: Client Interview

TABLE 2-15B. THERAPEUTIC SERVICES

VISN	SITE	FOLLOW- UP VETS #	MEDICATN MGMT %	MEDICAL SCREEN %	SEEN FOR SUB. ABUSE %	HOUSING SUPPORT %	VOCATION SUPPORT %
1	Bedford	130	84.4	86.2	69.7	65.7	47.7
1	Brockton	79	72.1	58.8	11.8	26.5	14.7
1	Togus	27	91.7	87.5	4.2	29.2	4.2
1	West Haven	62	82.7	71.2	50.0	61.5	30.8
2	Albany	49	85.3	73.5	52.9	72.7	38.2
2	Buffalo	83	55.8	28.8	19.2	23.1	
2	Canandaigua	101	73.6	86.2	20.7	29.9	6.9
2	Syracuse	53	45.0	32.5	15.0	40.0	20.0
3	Brooklyn	58	75.0	52.5	15.0	30.0	17.5
3	Montrose	102	75.8	87.9	5.5	12.1	2.2
3	New Jersey	89	88.6	67.1	22.9	45.7	17.4
3	Northport	103	71.6	64.8	21.6	55.7	29.5
4	Coatesville	101	70.4	75.3	32.1	72.8	18.5
4	Pittsburgh	136	82.4	40.7	16.7	21.3	8.3
5	Martinsburg	33	50.0	87.5	75.0	31.3	43.8
5	Perry Point	91	97.8	79.1	60.4	96.7	50.5
6	Fayetteville	27	65.2	65.2	17.4	39.1	4.3
6	Hampton	59	93.5	91.3	73.9	63.0	10.9
6	Salem	44	53.3	83.3	73.3	70.0	3.3
6	Salisbury	38	100.0	96.7	30.0	83.3	33.3
7	Atlanta	61	76.7	62.1	16.7	30.0	6.9
7	Augusta	71	83.3	91.7	58.3	60.0	37.3
7	Birmingham	25	94.7	89.5	52.6	68.4	
7	Tuscaloosa	69	97.8	89.1	13.0	47.8	21.7
7	Tuskegee	52	71.4	71.4	67.9	82.1	70.4
8	Gainesville	62	91.2	86.0	28.1	43.9	12.3
8	Miami	53	100.0	100.0	15.2	42.4	36.4
8	Tampa	52	61.7	68.1	12.8	29.8	6.4
10	Chillicothe	73	89.4	48.9	6.4	57.4	46.8
10	Cincinnati	116	81.0	71.4	36.9	61.9	17.9
10	Cleveland	169	73.6	69.8	36.8	54.7	30.2
10	Columbus	27	52.4	38.1	14.3	38.1	19.0
10	Dayton	110	65.6	76.7	18.0	37.7	18.0
10	Youngstown	45	97.2	94.4	48.6	55.6	47.2
11	Ann Arbor	54	100.0	84.8	30.4	73.9	32.6
11	Battle Creek	72	89.5	87.7	73.7	91.2	68.4
11	Detroit	94	95.3	84.9	19.8	37.2	7.0
11	Northern Indiana	82	89.4	66.7	27.3	74.2	18.2
12	Chicago-West Side	70	86.7	66.7	43.3	23.3	3.3
12	Madison	49	90.7	90.7	46.5	69.8	30.2
12	Milwaukee	33	68.8	81.3	62.5	75.0	56.3
12	North Chicago	118	70.4	76.1	25.9	69.7	26.4
12	Tomah	48	75.7	81.1	43.2	54.1	29.7
15	St. Louis	54	60.0	70.6	50.0	50.0	29.4
15	Topeka	112	95.1	95.1	27.2	81.5	8.6
16	Gulf Coast	61	55.8	63.5	32.7	40.4	9.6
16	Houston	64	93.1	93.1	15.5	34.5	6.9
16	Little Rock	49	100.0	87.8	31.7	56.1	22.0
16	New Orleans	58	97.1	77.1	40.0	25.7	25.7

VISN	SITE	FOLLOW- UP VETS #	MEDICATN MGMT %	MEDICAL SCREEN %	SEEN FOR SUB. ABUSE %	HOUSING SUPPORT %	VOCATION SUPPORT %
17	Dallas	73	92.8	85.5	33.3	46.4	10.1
17	Temple (Waco)	65	93.8	25.0		56.3	
18	Albuquerque	64	95.1	73.2	46.3	63.4	43.9
18	Phoenix	84	76.5	79.4	38.2	38.2	8.8
19	Denver	74	88.1	70.1	28.4	41.8	10.4
19	Grand Junction	48	76.3	81.6	21.1	28.9	2.6
19	Salt Lake City	56	95.7	95.7	32.6	78.3	13.3
19	Sheridan	18	93.3	100.0	53.3	26.7	6.7
19	Southern Colorado	97	91.2	87.7	17.5	53.6	26.8
20	American Lake	51	93.6	74.5	14.9	44.7	8.5
20	Boise	42	79.4	58.8	27.3	50.0	
20	Portland	78	96.9	86.2	15.4	50.8	9.2
20	Seattle	58	88.0	64.0	12.0	52.0	
21	Palo Alto	45	68.8	78.1	62.5	90.6	21.9
21	San Francisco	48	97.7	97.7	32.6	48.8	2.3
22	Greater Los Angeles	51	90.3	96.8	25.8	96.8	54.8
22	San Diego	48	81.8	72.7	81.8	84.8	57.6
23	Iowa City	50	70.5	59.1	9.1	22.7	11.4
23	Knoxville	90	73.0	86.5	50.6	40.4	22.5
23	Minneapolis	72	75.6	46.3	34.1	75.6	19.5
23	Omaha	42	91.2	79.4	29.4	11.8	8.8
23	St. Cloud	39	52.2	73.9	21.7	26.1	30.4
ALL SITES		4761	81.9	75.4	32.3	51.9	21.1
SITE AVERAGE		67.1	81.4	75.4	33.9	51.6	23.0
SITE STD. DEV.		28.8	14.4	17.0	19.8	21.2	17.1

Source: Client Interview

TABLE 2-16. CLIENT RATED THERAPEUTIC ALLIANCE

6 Month Pre-Entry vs. Follow-up

VISN	SITE	1 Pre-Entry N	2 Pre-Entry Mean	3 Follow-up Mean (2+4)	4 Change at Follow-up	5 Percent Change (4/2)
1	Bedford	93	37.90	44.93	7.04	18.6%
1	Brockton	34	37.42	38.52	1.09	2.9%
1	Togus	24	34.92	41.66	6.73	19.3%
1	West Haven	24	34.94	38.00	3.06	8.8%
2	Albany	20	39.76	49.98	10.22	25.7%
2	Buffalo	51	39.53	45.92	6.39	16.2%
2	Canandaigua	48	33.92	34.51	0.59	1.7%
2	Syracuse	29	36.51	40.53	4.02	11.0%
3	Brooklyn	39	34.66	38.17	3.51	10.1%
3	Montrose	46	33.45	33.15	-0.30	-0.9%
3	New Jersey	60	32.58	33.91	1.33	4.1%
3	Northport	18	33.99	32.31	-1.68	-5.0%
4	Coatesville	78	34.89	39.64	4.75	13.6%
4	Pittsburgh	115	37.08	39.73	2.65	7.1%
5	Martinsburg	29	39.01	47.54	8.53	21.9%
5	Perry Point	62	35.48	38.28	2.80	7.9%
6	Fayetteville	20	32.79	37.76	4.96	15.1%
6	Hampton	28	36.92	46.47	9.55	25.9%
6	Salem	32	37.34	41.54	4.20	11.2%
6	Salisbury	20	35.75	40.08	4.33	12.1%
7	Atlanta	34	36.11	42.98	6.86	19.0%
7	Augusta	69	36.64	39.64	3.00	8.2%
7	Birmingham	21	35.52	39.28	3.76	10.6%
7	Tuscaloosa	28	40.06	40.32	0.26	0.6%
7	Tuskegee	38	33.74	38.67	4.93	14.6%
8	Gainesville	46	34.11	40.03	5.92	17.4%
8	Miami	14	38.57	45.42	6.85	17.8%
8	Tampa	15	35.67	39.95	4.29	12.0%
10	Chillicothe	51	36.70	41.86	5.16	14.1%
10	Cincinnati	93	40.05	44.27	4.23	10.6%
10	Cleveland	119	37.29	41.74	4.45	11.9%
10	Columbus	23	35.88	41.85	5.97	16.6%
10	Dayton	88	36.57	41.45	4.88	13.3%
10	Youngstown	32	39.89	45.58	5.69	14.3%
11	Ann Arbor	36	36.11	39.65	3.53	9.8%
11	Battle Creek	44	36.91	40.77	3.86	10.5%
11	Detroit	54	33.01	35.54	2.53	7.7%
11	Northern Indiana	35	35.37	38.02	2.64	7.5%
12	Chicago-West Side	39	38.85	43.10	4.26	11.0%
12	Madison	46	36.94	38.87	1.93	5.2%
12	Milwaukee	32	33.59	36.28	2.69	8.0%
12	North Chicago	92	35.74	37.01	1.27	3.6%
12	Tomah	20	38.20	38.57	0.37	1.0%
15	St. Louis	42	29.65	34.90	5.25	17.7%
15	Topeka	29	34.05	37.03	2.98	8.8%
16	Gulf Coast	41	35.73	42.81	7.09	19.8%
16	Houston	55	36.84	40.71	3.87	10.5%
16	Little Rock	36	35.65	38.57	2.92	8.2%
16	New Orleans	21	32.00	35.05	3.05	9.5%
17	Dallas	66	37.59	37.45	-0.14	-0.4%
17	Temple (Waco)	58	37.85	36.66	-1.19	-3.2%

TABLE 2-16. CLIENT RATED THERAPEUTIC ALLIANCE

6 Month Pre-Entry vs. Follow-up

VISN	SITE	1 Pre-Entry N	2 Pre-Entry Mean	3 Follow-up Mean (2+4)	4 Change at Follow-up	5 Percent Change (4/2)
18	Albuquerque	51	40.26	40.10	-0.16	-0.4%
18	Phoenix	39	36.84	31.75	-5.10	-13.8%
19	Denver	62	38.10	43.12	5.03	13.2%
19	Grand Junction	41	38.72	41.56	2.85	7.4%
19	Salt Lake City	48	36.10	39.27	3.16	8.8%
19	Sheridan	17	36.03	39.86	3.83	10.6%
19	Southern Colorado	81	34.96	37.96	3.00	8.6%
20	American Lake	32	34.85	37.85	3.00	8.6%
20	Boise	39	35.99	39.61	3.62	10.1%
20	Portland	33	36.00	38.30	2.30	6.4%
20	Seattle	38	37.48	36.76	-0.72	-1.9%
21	Palo Alto	37	30.42	35.49	5.07	16.7%
21	San Francisco	36	34.65	34.80	0.15	0.4%
22	Greater Los Angeles	37	34.60	39.24	4.64	13.4%
22	San Diego	36	38.03	45.85	7.82	20.6%
23	Iowa City	44	36.19	39.92	3.73	10.3%
23	Knoxville	78	35.15	37.24	2.10	6.0%
23	Minneapolis	64	32.46	35.24	2.77	8.5%
23	Omaha	27	38.99	45.06	6.06	15.6%
23	St. Cloud	32	36.43	40.77	4.34	11.9%
ALL SITES		3159	36.18	39.76	3.58	9.91%
SITE AVERAGE		44.49	36.08	39.67	3.58	9.92%
SITE STD. DEV.		23.08	2.23	3.66	2.64	7.14%

Change values are least squares means derived from analysis of covariance including site,time, baseline value, and eleven other baseline covariates

Shaded values represent reductions in alliance at follow-up

Bold/Underlined values represent adjusted positive outliers

Source: Client Interview

TABLE 2-17. FIDELITY TO ASSERTIVE COMMUNITY TREATMENT MODEL.

VISN	SITE	HUMAN RESOURCES	ORGANIZ'L BOUNDARIES	SERVICES	SUB. ABUSE TX	TOTAL SCORE	AVG SCORE
1	Bedford	3.8	4.0	4.2	4.3	89.0	4.10
1	Brockton	4.7	4.7	4.0	3.0	94.0	4.30
1	Togus	4.3	4.7	3.5	2.0	86.0	3.90
1	West Haven	4.5	4.6	4.7	3.3	97.0	4.40
2	Albany	4.0	3.7	3.7	4.0	84.0	3.80
2	Buffalo	3.5	4.4	4.2	1.7	82.0	3.70
2	Canandaigua	3.7	4.3	3.3	3.3	82.0	3.70
2	Syracuse	3.8	4.4	3.7	1.7	81.0	3.70
3	Brooklyn	3.0	4.3	3.2	2.7	75.0	3.40
3	Montrose	4.3	4.7	3.2	3.0	87.0	4.00
3	New Jersey	4.3	4.1	4.2	3.0	89.0	4.10
3	Northport	3.0	4.7	4.3	2.7	85.0	3.90
4	Coatesville	3.5	4.7	3.2	2.3	80.0	3.60
4	Pittsburgh	4.3	4.3	4.0	2.3	87.0	4.00
5	Martinsburg	4.2	4.7	3.7	3.7	91.0	4.10
5	Perry Point	4.2	4.7	4.7	4.0	98.0	4.50
6	Fayetteville	4.0	4.4	3.3	2.7	83.0	3.80
6	Hampton	3.5	4.4	4.3	4.0	90.0	4.10
6	Salem	4.2	4.4	3.8	2.3	86.0	3.90
6	Salisbury	4.2	4.3	4.2	2.3	87.0	4.00
7	Atlanta	4.2	4.6	3.5	3.3	88.0	4.00
7	Augusta	3.2	4.9	5.0	5.0	98.0	4.50
7	Birmingham	4.3	4.3	4.0	4.7	92.0	4.20
7	Tuscaloosa	4.5	5.0	4.3	3.0	97.0	4.40
7	Tuskegee	4.0	4.6	3.8	2.0	85.0	3.90
8	Gainesville	4.3	4.0	4.3	3.0	89.0	4.10
8	Miami	3.5	4.4	3.5	2.7	81.0	3.70
8	Tampa	3.7	4.3	4.3	2.0	84.0	3.80
10	Chillicothe	4.2	4.3	3.7	2.7	85.0	3.90
10	Cincinnati	4.2	4.4	4.0	3.7	93.0	4.20
10	Cleveland	4.5	4.6	3.7	3.0	90.0	4.10
10	Columbus	2.7	3.6	3.3	2.0	67.0	3.10
10	Dayton	3.5	4.0	3.8	3.0	80.0	3.60
10	Youngstown	4.3	5.0	4.3	3.7	98.0	4.50
11	Ann Arbor	4.7	4.9	4.2	4.3	100.0	4.60
11	Battle Creek	3.7	4.9	4.0	2.3	87.0	4.00
11	Detroit	4.2	3.3	3.3	2.0	74.0	3.40
11	Northern Indiana	4.3	4.7	4.2	2.0	90.0	4.10
12	Chicago-West Side	4.3	4.1	4.0	3.0	88.0	4.00
12	Madison	4.5	4.9	4.2	5.0	101.0	4.60
12	Milwaukee	4.2	4.1	4.7	3.3	92.0	4.20
12	North Chicago	4.0	4.4	3.7	2.0	83.0	3.80
12	Tomah	4.7	4.0	4.3	3.7	93.0	4.20
15	St. Louis	3.8	4.6	4.2	4.0	92.0	4.20
15	Topeka	4.7	4.9	4.0	3.7	97.0	4.40
16	Gulf Coast	3.7	4.1	3.5	2.7	80.0	3.60
16	Houston	4.8	4.9	4.0	1.3	91.0	4.10
16	Little Rock	4.5	4.9	4.3	3.3	97.0	4.40
16	New Orleans	4.7	5.0	3.5	3.7	95.0	4.30

VISN	SITE	HUMAN RESOURCES	ORGANIZ'L BOUNDARIES	SERVICES	SUB. ABUSE TX	TOTAL SCORE	AVG SCORE
17	Dallas	3.2	4.3	3.8	2.7	80.0	3.60
17	Temple (Waco)	3.8	4.0	3.7	2.7	81.0	3.70
18	Albuquerque	4.7	4.0	4.3	2.7	90.0	4.10
18	Phoenix	3.8	4.3	3.8	2.0	82.0	3.70
19	Denver	3.5	4.9	3.8	2.7	86.0	3.90
19	Grand Junction	4.0	4.7	4.3	5.0	98.0	<u>4.50</u>
19	Salt Lake City	3.3	4.3	3.8	3.3	83.0	3.80
19	Sheridan	3.0	5.0	3.7	3.7	86.0	3.90
19	Southern Colorado	4.3	4.6	3.8	1.0	84.0	3.80
20	American Lake	4.3	4.7	4.2	2.7	92.0	4.20
20	Boise	4.3	4.7	4.2	3.7	95.0	<u>4.30</u>
20	Portland	4.2	4.3	3.7	2.3	84.0	3.80
20	Seattle	4.2	3.9	3.3	2.3	79.0	3.60
21	Palo Alto	3.3	4.1	4.7	2.3	84.0	3.80
21	San Francisco	4.0	4.7	4.2	2.7	90.0	4.10
22	Greater Los Angeles	3.6	4.7	4.2	2.3	83.0	3.80
22	San Diego	4.5	4.6	4.0	3.0	92.0	4.20
23	Iowa City	4.0	4.6	4.3	2.7	90.0	4.10
23	Knoxville	4.5	4.1	4.2	2.0	87.0	4.00
23	Minneapolis	4.2	4.4	4.2	2.3	88.0	4.00
23	Omaha	4.8	3.4	3.5	1.7	79.0	3.60
23	St. Cloud	3.0	4.3	3.5	3.7	80.0	3.60
SITE AVERAGE		4.0	4.4	3.9	2.9	87.5	4.0
SITE STD. DEV.		0.5	0.4	0.4	0.9	6.6	0.31

Source: Assertive Community Treatment Fidelity Scale from the FY 2004 Annual Progress Report.
Total score range: 22-110

Shaded values exceed one standard deviation from the mean in undesired direction.

TABLE 2-18. VA HOSPITAL USE 183 DAYS PRE -vs- POST-ENTRY PTF FY04

VISN SITE	Total N FY02	1 N 183 Days	2 Pre-IDF MH Days/ Veteran	3 Post-IDF MH Days/ Veteran	4 Change MH Days/ Veteran (col.3-2)	5 % Change MH Days (4/2)	6 Change MH Cost*/ Inp't Veteran (4x\$1,011)
1 Bedford	130	128	37.8	24.1	-13.7	-36.2%	(\$13,830)
1 Brockton	79	49	89.0	8.2	-80.8	-90.8%	(\$81,664)
1 Togus	27	26	52.8	20.4	-32.3	-61.3%	(\$32,702)
1 West Haven	62	33	66.4	28.6	-37.8	-57.0%	(\$38,265)
2 Albany	49	36	30.9	7.6	-23.3	-75.4%	(\$23,562)
2 Buffalo	83	57	14.4	5.6	-8.8	-61.1%	(\$8,886)
2 Canandaigua	101	68	62.6	4.6	-58.0	-92.6%	(\$58,608)
2 Syracuse	53	38	33.7	11.5	-22.3	-66.0%	(\$22,508)
3 Brooklyn	58	51	48.3	19.8	-28.5	-58.9%	(\$28,804)
3 Montrose	102	79	137.2	19.0	-118.2	-86.2%	(\$119,464)
3 New Jersey	89	79	29.9	11.8	-18.1	-60.4%	(\$18,262)
3 Northport	103	98	31.9	18.9	-13.0	-40.6%	(\$13,102)
4 Coatesville	101	91	71.2	16.3	-54.9	-77.1%	(\$55,505)
4 Pittsburgh	136	123	56.3	11.4	-44.9	-79.8%	(\$45,355)
5 Martinsburg	33	23	23.7	7.3	-16.3	-69.1%	(\$16,528)
5 Perry Point	91	91	120.1	11.3	-108.8	-90.6%	(\$109,966)
6 Fayetteville	27	24	23.2	7.0	-16.2	-69.8%	(\$16,345)
6 Hampton	59	52	29.3	9.5	-19.8	-67.5%	(\$19,987)
6 Salem	44	41	21.3	5.7	-15.7	-73.4%	(\$15,831)
6 Salisbury	38	31	71.2	22.8	-48.3	-67.9%	(\$48,854)
7 Atlanta	61	58	30.6	9.0	-21.5	-70.4%	(\$21,754)
7 Augusta	71	71	117.1	13.1	-104.0	-88.8%	(\$105,172)
7 Birmingham	25	21	64.6	19.7	-44.9	-69.5%	(\$45,399)
7 Tuscaloosa	69	65	76.5	17.9	-58.6	-76.6%	(\$59,213)
7 Tuskegee	52	46	35.2	15.9	-19.3	-54.8%	(\$19,473)
8 Gainesville	62	60	30.6	6.2	-24.4	-79.7%	(\$24,635)
8 Miami	53	50	35.7	17.1	-18.6	-52.1%	(\$18,825)
8 Tampa	52	47	24.0	10.5	-13.5	-56.3%	(\$13,681)
10 Chillicothe	73	68	40.9	18.8	-22.2	-54.2%	(\$22,420)
10 Cincinnati	116	104	20.3	7.4	-12.9	-63.4%	(\$13,017)
10 Cleveland	169	139	37.3	14.4	-22.9	-61.4%	(\$23,115)
10 Columbus	27	21	24.8	10.0	-14.9	-59.9%	(\$15,021)
10 Dayton	110	84	8.7	5.5	-3.2	-37.1%	(\$3,250)
10 Youngstown	45	43	9.9	0.8	-9.1	-92.0%	(\$9,193)
11 Ann Arbor	54	50	34.9	9.9	-25.0	-71.5%	(\$25,235)
11 Battle Creek	72	70	73.5	20.9	-52.6	-71.6%	(\$53,164)
11 Detroit	94	90	35.9	12.7	-23.1	-64.5%	(\$23,388)
11 Northern Indiana	82	67	36.5	11.7	-24.7	-67.8%	(\$25,003)
12 Chicago-West Side	70	67	44.1	12.3	-31.8	-72.2%	(\$32,156)
12 Madison	49	46	29.5	7.6	-21.9	-74.3%	(\$22,154)
12 Milwaukee	33	31	8.0	2.5	-5.5	-68.1%	(\$5,512)
12 North Chicago	118	116	54.8	8.2	-46.7	-85.1%	(\$47,168)
12 Tomah	48	41	5.7	2.2	-3.5	-62.0%	(\$3,575)
15 St. Louis	54	44	24.2	11.1	-13.1	-54.0%	(\$13,212)
15 Topeka	112	102	37.8	22.6	-15.1	-40.1%	(\$15,304)
16 Gulf Coast	61	53	46.2	14.6	-31.6	-68.4%	(\$31,932)
16 Houston	64	61	22.4	8.6	-13.8	-61.5%	(\$13,955)
16 Little Rock	49	47	47.5	31.4	-16.1	-34.0%	(\$16,327)
16 New Orleans	58	53	24.5	9.9	-14.5	-59.4%	(\$14,688)
17 Dallas	73	71	40.4	11.3	-29.1	-72.0%	(\$29,447)
17 Temple (Waco)	65	57	52.8	9.1	-43.7	-82.7%	(\$44,182)

VISN SITE	Total N FY02	1 N 183 Days	2 Pre-IDF MH Days/ Veteran	3 Post-IDF MH Days/ Veteran	4 Change MH Days/ Veteran (col.3-2)	5 % Change MH Days (4/2)	6 Change MH Cost*/ Inp't Veteran (4x\$1,011)
18 Albuquerque	64	45	30.8	14.1	-16.7	-54.3%	(\$16,895)
18 Phoenix	84	73	17.1	10.5	-6.6	-38.8%	(\$6,717)
19 Denver	74	71	49.8	15.3	-34.5	-69.3%	(\$34,915)
19 Grand Junction	48	43	17.4	7.4	-10.0	-57.4%	(\$10,086)
19 Salt Lake City	56	53	16.8	10.0	-6.8	-40.6%	(\$6,924)
19 Sheridan	18	17	61.1	7.5	-53.6	-87.8%	(\$54,237)
19 Southern Colorado	97	91	9.1	1.6	-7.5	-82.3%	(\$7,588)
20 American Lake	51	48	63.5	13.2	-50.3	-79.2%	(\$50,824)
20 Boise	42	40	12.9	8.2	-4.7	-36.3%	(\$4,726)
20 Portland	78	70	37.5	13.3	-24.1	-64.4%	(\$24,394)
20 Seattle	58	42	17.6	2.1	-15.5	-88.2%	(\$15,719)
21 Palo Alto	45	41	44.2	17.9	-26.3	-59.5%	(\$26,631)
21 San Francisco	48	45	37.9	7.5	-30.4	-80.2%	(\$30,689)
22 Greater Los Angeles	51	49	64.1	28.0	-36.1	-56.4%	(\$36,520)
22 San Diego	48	35	31.2	6.1	-25.1	-80.5%	(\$25,362)
23 Iowa City	50	45	24.8	11.4	-13.4	-53.9%	(\$13,525)
23 Knoxville	90	88	17.2	3.7	-13.5	-78.5%	(\$13,683)
23 Minneapolis	72	70	67.8	4.8	-63.0	-92.9%	(\$63,693)
23 Omaha	42	34	16.3	4.6	-11.6	-71.5%	(\$11,775)
23 St. Cloud	39	37	22.6	12.8	-9.8	-43.5%	(\$9,946)
ALL SITES	4761	4198	42.5	12.2	-30.3	-71.3%	(\$30,678)
SITE AVERAGE	67	59	40.6	11.9	-28.7	-66.5%	(\$29,063)
SITE STD. DEV.	29	26	25.9	6.6	23.6	15.2%	\$23,843

*FY 2004 National general psychiatry per diem=\$1011(NMHPMS).

Total N FY04=IDF3 Table <10/01/04 (including terminated clients)

Shaded values exceed one standard deviation from the mean in undesired direction. Bold /Underlined values represent positive outliers.

Source: VA automated Patient Treatment File FY02; NMHPMS FY04

TABLE 2-18a. VA HOSPITAL USE 365 DAYS PRE -vs- POST-ENTRY PTF FY04

VISN	SITE	Total N FY02	1 N 365 Days	2 Pre-IDF MH Days/ Veteran	3 Post-IDF MH Days/ Veteran	4 Change MH Days/ Veteran (col. 3-2)	5 % Change MH Days/ (4/2)	6 Change MH Cost*/ Inp't Veteran (4x\$1011)
1	Bedford	130	115	56.8	34.5	-22.2	-39.2%	(\$22,471)
1	Brockton	79	43	178.6	17.8	-160.7	-90.0%	(\$162,489)
1	Togus	27	22	88.0	27.9	-60.1	-68.3%	(\$60,752)
1	West Haven	62	31	101.5	52.4	-49.1	-48.4%	(\$49,637)
2	Albany	49	30	38.4	12.4	-26.0	-67.7%	(\$26,252)
2	Buffalo	83	54	19.6	13.2	-6.4	-32.7%	(\$6,478)
2	Canandaigua	101	67	118.5	9.8	-108.7	-91.7%	(\$109,867)
2	Syracuse	53	35	36.5	19.1	-17.4	-47.7%	(\$17,591)
3	Brooklyn	58	44	64.8	34.1	-30.8	-47.4%	(\$31,088)
3	Montrose	102	76	248.5	38.9	-209.6	-84.3%	(\$211,858)
3	New Jersey	89	75	54.2	23.7	-30.5	-56.3%	(\$30,856)
3	Northport	103	90	60.4	31.1	-29.3	-48.5%	(\$29,611)
4	Coatesville	101	78	125.1	32.8	-92.3	-73.8%	(\$93,362)
4	Pittsburgh	136	112	82.6	21.9	-60.7	-73.5%	(\$61,364)
5	Perry Point	91	88	201.7	22.8	-178.9	-88.7%	(\$180,900)
6	Fayetteville	27	22	45.9	8.8	-37.1	-80.9%	(\$37,545)
6	Hampton	59	47	49.9	16.0	-33.9	-67.9%	(\$34,245)
6	Salem	44	35	33.9	18.3	-15.7	-46.2%	(\$15,858)
6	Salisbury	38	28	123.2	34.5	-88.7	-72.0%	(\$89,690)
7	Atlanta	61	56	37.8	15.6	-22.2	-58.7%	(\$22,441)
7	Augusta	71	66	189.5	20.1	-169.4	-89.4%	(\$171,257)
7	Birmingham	25	14	141.3	64.8	-76.5	-54.1%	(\$77,342)
7	Tuscaloosa	69	58	118.0	30.8	-87.1	-73.9%	(\$88,096)
7	Tuskegee	52	43	55.7	28.7	-27.0	-48.5%	(\$27,321)
8	Gainesville	62	59	46.3	12.9	-33.4	-72.2%	(\$33,774)
8	Miami	53	49	55.2	26.6	-28.6	-51.8%	(\$28,906)
8	Tampa	52	39	34.1	17.0	-17.0	-50.0%	(\$17,213)
10	Chillicothe	73	60	76.7	33.9	-42.7	-55.7%	(\$43,203)
10	Cincinnati	116	59	32.9	19.3	-13.5	-41.2%	(\$13,691)
10	Cleveland	169	119	62.6	21.7	-40.9	-65.3%	(\$41,349)
10	Columbus	27	21	39.9	17.7	-22.1	-55.6%	(\$22,386)
10	Dayton	110	45	18.9	16.0	-2.8	-15.1%	(\$2,876)
10	Youngstown	45	36	13.2	5.2	-8.0	-60.6%	(\$8,088)
11	Ann Arbor	54	47	56.0	21.5	-34.5	-61.6%	(\$34,869)
11	Battle Creek	72	64	122.6	43.5	-79.1	-64.5%	(\$79,964)
11	Detroit	94	90	50.3	18.9	-31.4	-62.4%	(\$31,700)
11	Northern Indiana	82	61	75.7	26.3	-49.4	-65.3%	(\$49,937)
12	Chicago-West Side	70	61	63.9	23.9	-40.0	-62.6%	(\$40,407)
12	Madison	49	45	45.2	9.6	-35.5	-78.7%	(\$35,924)
12	Milwaukee	33	26	12.8	8.7	-4.2	-32.6%	(\$4,238)
12	North Chicago	118	110	79.5	15.8	-63.7	-80.2%	(\$64,437)
12	Tomah	48	35	11.3	3.9	-7.4	-65.5%	(\$7,510)
15	St. Louis	54	28	37.0	16.4	-20.6	-55.7%	(\$20,834)
15	Topeka	112	93	61.7	28.5	-33.3	-53.9%	(\$33,624)
16	Gulf Coast	61	47	68.1	27.1	-41.0	-60.2%	(\$41,451)
16	Houston	64	60	34.0	15.1	-18.9	-55.6%	(\$19,108)
16	Little Rock	49	45	70.4	56.3	-14.1	-20.0%	(\$14,266)
16	New Orleans	58	41	29.5	22.8	-6.7	-22.8%	(\$6,781)
17	Dallas	73	67	55.4	17.0	-38.4	-69.2%	(\$38,795)
17	Temple (Waco)	65	57	78.4	18.7	-59.6	-76.1%	(\$60,305)
18	Albuquerque	64	30	49.4	27.6	-21.8	-44.2%	(\$22,074)
18	Phoenix	84	64	29.0	16.4	-12.6	-43.5%	(\$12,764)
19	Denver	74	68	67.2	25.8	-41.3	-61.6%	(\$41,793)

VISN	SITE	Total N FY02	1 N 365 Days	2 Pre-IDF MH Days/ Veteran	3 Post-IDF MH Days/ Veteran	4 Change MH Days/ Veteran (col 3-2)	5 % Change MH Days/ (4/2)	6 Change MH Cost*/ Inp't Veteran (4x\$1011)
19	Grand Junction	48	41	25.1	14.2	-10.9	-43.4%	(\$11,022)
19	Salt Lake City	56	50	32.2	14.0	-18.2	-56.6%	(\$18,441)
19	Sheridan	18	15	81.3	11.2	-70.1	-86.2%	(\$70,837)
19	Southern Colorado	97	90	16.3	3.0	-13.3	-81.3%	(\$13,424)
20	American Lake	51	45	84.5	21.6	-63.0	-74.5%	(\$63,648)
20	Boise	42	36	25.8	12.3	-13.4	-52.2%	(\$13,592)
20	Portland	78	63	47.9	19.8	-28.1	-58.7%	(\$28,420)
20	Seattle	58	37	35.6	10.8	-24.8	-69.8%	(\$25,111)
21	Palo Alto	45	40	77.7	26.0	-51.7	-66.5%	(\$52,243)
21	San Francisco	48	38	54.8	8.6	-46.2	-84.3%	(\$46,692)
22	Greater Los Angeles	51	46	93.8	42.0	-51.8	-55.2%	(\$52,396)
22	San Diego	48	17	49.8	10.4	-39.4	-79.1%	(\$39,845)
23	Iowa City	50	38	34.7	21.2	-13.6	-39.0%	(\$13,702)
23	Knoxville	90	85	31.4	8.4	-23.0	-73.3%	(\$23,241)
23	Minneapolis	72	69	97.0	6.9	-90.1	-92.9%	(\$91,063)
23	Omaha	42	26	25.2	4.9	-20.3	-80.5%	(\$20,492)
23	St. Cloud	39	32	34.3	20.1	-14.2	-41.4%	(\$14,344)
ALL SITES		4728	3723	69.8	21.6	-48.2	-69.0%	(\$48,708)
SITE AVERAGE		68	53	65.6	21.4	-44.2	-61.3%	(\$44,702)
SITE STD. DEV.		29	25	45.6	11.9	41.4	17.4%	\$41,560

*FY 2004 National general psychiatry per diem=\$1011(NMHPPMS).

Total N FY04=IDF3 Table <10/01/04 (including terminated)

Shaded values exceed one standard deviation from the mean in undesired direction. Bold /Underlined values represent positive outliers.

Source: VA automated Patient Treatment File FY04; NMHPPMS FY04

TABLE 2-18b. VA HOSPITAL USE 548 DAYS PRE -vs- POST-ENTRY PTF FY04

VISN	SITE	Total N FY02	1 N 548 Days	2 Pre-IDF MH Days/ Veteran	3 Post-IDF MH Days/ Veteran	4 Change MH Days/ Veteran (col 3-2)	5 % Change MH Days/ (4/2)	6 Change MH Cost*/ Inp't Veteran (4x\$1011)
1	Bedford	130	95	79.5	45.5	-34.0	-42.7%	(\$34,331)
1	Brockton	79	38	275.2	32.3	-242.9	-88.3%	(\$245,593)
1	Togus	27	19	120.3	40.1	-80.2	-66.7%	(\$81,093)
1	West Haven	62	25	136.9	51.8	-85.1	-62.2%	(\$86,056)
2	Albany	49	28	45.4	16.8	-28.7	-63.1%	(\$28,994)
2	Buffalo	83	49	26.3	21.2	-5.1	-19.3%	(\$5,138)
2	Canandaigua	101	64	175.2	12.8	-162.3	-92.7%	(\$164,098)
2	Syracuse	53	32	47.4	23.0	-24.3	-51.4%	(\$24,612)
3	Brooklyn	58	41	83.8	46.8	-37.0	-44.2%	(\$37,432)
3	Montrose	102	74	358.6	65.1	-293.5	-81.9%	(\$296,769)
3	New Jersey	89	66	75.6	30.0	-45.6	-60.3%	(\$46,123)
3	Northport	103	82	109.4	34.8	-74.6	-68.2%	(\$75,467)
4	Coatesville	101	70	176.7	52.7	-124.0	-70.2%	(\$125,335)
4	Pittsburgh	136	98	110.9	29.3	-81.6	-73.6%	(\$82,500)
5	Perry Point	91	88	269.2	37.1	-232.2	-86.2%	(\$234,713)
6	Fayetteville	27	15	74.5	11.1	-63.5	-85.2%	(\$64,165)
6	Hampton	59	39	73.1	19.9	-53.1	-72.7%	(\$53,713)
6	Salem	44	26	51.0	20.0	-31.0	-60.8%	(\$31,341)
6	Salisbury	38	20	203.2	57.6	-145.6	-71.7%	(\$147,202)
7	Atlanta	61	56	48.6	20.5	-28.2	-57.9%	(\$28,489)
7	Augusta	71	60	267.1	29.1	-238.0	-89.1%	(\$240,618)
7	Tuscaloosa	69	49	142.7	47.6	-95.2	-66.7%	(\$96,210)
7	Tuskegee	52	38	78.0	39.1	-39.0	-49.9%	(\$39,402)
8	Gainesville	62	55	64.1	16.5	-47.5	-74.2%	(\$48,032)
8	Miami	53	47	68.4	33.7	-34.7	-50.7%	(\$35,062)
8	Tampa	52	31	44.1	25.2	-18.9	-42.9%	(\$19,144)
10	Chillicothe	73	52	121.6	41.9	-79.7	-65.5%	(\$80,549)
10	Cincinnati	116	54	41.5	26.6	-15.0	-36.1%	(\$15,146)
10	Cleveland	169	108	87.9	29.8	-58.0	-66.1%	(\$58,666)
10	Columbus	27	17	59.8	29.2	-30.6	-51.2%	(\$30,925)
10	Dayton	110	41	25.5	23.4	-2.1	-8.1%	(\$2,096)
10	Youngstown	45	34	21.3	7.3	-14.0	-65.7%	(\$14,154)
11	Ann Arbor	54	47	70.3	27.2	-43.1	-61.3%	(\$43,602)
11	Battle Creek	72	58	165.9	62.4	-103.5	-62.4%	(\$104,621)
11	Detroit	94	85	63.6	22.4	-41.2	-64.8%	(\$41,653)
11	Northern Indiana	82	46	85.8	48.3	-37.5	-43.8%	(\$37,956)
12	Chicago-West Side	70	59	83.1	32.0	-51.1	-61.5%	(\$51,647)
12	Madison	49	40	68.9	17.4	-51.5	-74.8%	(\$52,092)
12	Milwaukee	33	23	22.5	19.3	-3.3	-14.5%	(\$3,297)
12	North Chicago	118	102	112.6	24.2	-88.4	-78.5%	(\$89,404)
12	Tomah	48	33	19.0	7.5	-11.5	-60.3%	(\$11,581)
15	St. Louis	54	15	46.4	11.9	-34.5	-74.3%	(\$34,846)
15	Topeka	112	81	87.3	29.5	-57.8	-66.2%	(\$58,438)
16	Gulf Coast	61	42	78.2	39.7	-38.5	-49.2%	(\$38,924)
16	Houston	64	51	51.1	21.3	-29.8	-58.3%	(\$30,152)
16	Little Rock	49	39	75.6	62.2	-13.4	-17.7%	(\$13,532)
16	New Orleans	58	33	32.5	26.4	-6.1	-18.8%	(\$6,189)
17	Dallas	73	58	66.0	25.8	-40.2	-60.9%	(\$40,614)
17	Temple (Waco)	65	57	91.7	28.1	-63.6	-69.4%	(\$64,332)
18	Albuquerque	64	10	81.4	20.9	-60.5	-74.3%	(\$61,166)
18	Phoenix	84	48	39.3	26.6	-12.8	-32.5%	(\$12,911)

VISN	SITE	Total N FY02	1 N 548 Days	2 Pre-IDF MH Days/ Veteran	3 Post-IDF MH Days/ Veteran	4 Change MH Days/ Veteran (col 3-2)	5 % Change MH Days/ (4/2)	6 Change MH Cost*/ Inp't Veteran (4x\$1011)
19	Denver	74	66	79.3	37.8	-41.5	-52.3%	(\$41,987)
19	Grand Junction	48	36	29.2	17.9	-11.3	-38.6%	(\$11,402)
19	Salt Lake City	56	47	48.6	16.2	-32.4	-66.7%	(\$32,739)
19	Sheridan	18	13	79.1	19.2	-59.9	-75.8%	(\$60,582)
19	Southern Colorado	97	88	24.0	3.4	-20.6	<u>-85.8%</u>	(\$20,852)
20	American Lake	51	43	108.4	26.7	-81.7	-75.4%	(\$82,596)
20	Boise	42	33	39.4	16.6	-22.8	-58.0%	(\$23,100)
20	Portland	78	58	52.3	28.1	-24.3	-46.4%	(\$24,543)
20	Seattle	58	33	42.2	20.0	-22.2	-52.5%	(\$22,395)
21	Palo Alto	45	34	115.2	36.6	-78.5	-68.2%	(\$79,393)
21	San Francisco	48	37	59.8	10.3	-49.5	<u>-82.8%</u>	(\$50,031)
22	Greater Los Angeles	51	44	128.1	49.1	-79.0	-61.7%	(\$79,869)
23	Iowa City	50	26	49.9	41.5	-8.4	-16.8%	(\$8,477)
23	Knoxville	90	81	42.2	13.0	-29.2	-69.2%	(\$29,519)
23	Minneapolis	72	66	120.5	11.3	-109.2	<u>-90.6%</u>	(\$110,413)
23	Omaha	42	14	32.9	7.5	-25.4	-77.2%	(\$25,636)
23	St. Cloud	39	28	46.4	33.6	-12.8	-27.6%	(\$12,926)
ALL SITES		4655	3285	96.8	29.8	-67.0	-69.2%	(\$67,737)
SITE AVERAGE		68	48	88.3	28.8	-59.4	-59.9%	(\$60,097)
SITE STD. DEV.		28	23	65.3	14.2	58.6	19.7%	\$59,256

*FY 2004 National general psychiatry per diem=\$1011(NMHPPMS).

Total N FY04=IDF3 Table <10/01/04 (including terminated)

Shaded values exceed one standard deviation from the mean in undesired direction. Bold /Underlined values represent positive outliers.

Source: VA automated Patient Treatment File FY04; NMHPPMS FY04

TABLE 2-18c. VA HOSPITAL USE 730 DAYS PRE -vs- POST-ENTRY PTF FY04

VISN	SITE	Total N FY02	1 N 730 Days	2 Pre-IDF MH Days/ Veteran	3 Post-IDF MH Days/ Veteran	4 Change MH Days/ Veteran (col 3-2)	5 % Change MH Days/ (4/2)	6 Change MH Cost*/ Inp't Veteran (4x\$1011)
1 Bedford		130	80	103.2	51.3	-51.9	-50.3%	(\$52,446)
1 Brockton		79	38	348.3	41.0	-307.2	-88.2%	(\$310,616)
1 Togus		27	18	156.8	51.4	-105.3	-67.2%	(\$106,492)
1 West Haven		62	23	162.7	65.0	-97.7	-60.1%	(\$98,814)
2 Albany		49	26	53.6	25.0	-28.6	-53.4%	(\$28,930)
2 Buffalo		83	45	33.6	20.4	-13.1	-39.1%	(\$13,278)
2 Canandaigua		101	63	244.1	18.7	-225.5	-92.4%	(\$227,940)
2 Syracuse		53	28	52.0	30.8	-21.3	-40.9%	(\$21,520)
3 Brooklyn		58	41	94.9	53.1	-41.8	-44.0%	(\$42,240)
3 Montrose		102	70	467.1	89.3	-377.7	-80.9%	(\$381,869)
3 New Jersey		89	64	112.5	37.5	-75.0	-66.6%	(\$75,778)
3 Northport		103	77	177.9	48.8	-129.2	-72.6%	(\$130,577)
4 Coatesville		101	64	222.5	60.8	-161.6	-72.7%	(\$163,419)
4 Pittsburgh		136	92	134.0	36.9	-97.1	-72.5%	(\$98,188)
5 Perry Point		91	80	356.4	47.9	-308.5	-86.6%	(\$311,843)
6 Fayetteville		27	12	88.7	14.3	-74.3	-83.8%	(\$75,151)
6 Hampton		59	30	86.0	26.3	-59.7	-69.4%	(\$60,390)
6 Salem		44	24	62.9	33.1	-29.8	-47.4%	(\$30,162)
6 Salisbury		38	18	255.3	70.4	-184.9	-72.4%	(\$186,923)
7 Atlanta		61	56	59.6	23.2	-36.4	-61.1%	(\$36,793)
7 Augusta		71	57	344.1	39.7	-304.4	-88.5%	(\$307,752)
7 Tuscaloosa		69	36	164.9	67.1	-97.9	-59.3%	(\$98,966)
7 Tuskegee		52	35	95.1	46.0	-49.0	-51.6%	(\$49,568)
8 Gainesville		62	52	74.6	20.5	-54.1	-72.5%	(\$54,711)
8 Miami		53	41	84.6	47.0	-37.5	-44.4%	(\$37,925)
8 Tampa		52	28	58.7	39.0	-19.7	-33.5%	(\$19,895)
10 Chillicothe		73	48	165.5	52.2	-113.2	-68.4%	(\$114,475)
10 Cincinnati		116	50	48.6	34.4	-14.2	-29.3%	(\$14,397)
10 Cleveland		169	93	108.6	36.2	-72.4	-66.7%	(\$73,194)
10 Columbus		27	13	71.0	29.5	-41.5	-58.4%	(\$41,918)
10 Dayton		110	37	28.7	27.6	-1.1	-3.7%	(\$1,066)
10 Youngstown		45	29	25.3	7.1	-18.2	-72.0%	(\$18,407)
11 Ann Arbor		54	42	96.5	30.4	-66.1	-68.5%	(\$66,846)
11 Battle Creek		72	48	216.7	81.8	-134.9	-62.2%	(\$136,359)
11 Detroit		94	76	81.2	29.9	-51.3	-63.2%	(\$51,854)
11 Northern Indiana		82	45	118.4	57.9	-60.5	-51.1%	(\$61,154)
12 Chicago-West Side		70	54	93.0	40.4	-52.5	-56.5%	(\$53,115)
12 Madison		49	37	83.7	28.2	-55.5	-66.3%	(\$56,097)
12 Milwaukee		33	20	24.1	33.9	9.9	41.0%	\$9,958
12 North Chicago		118	90	146.1	31.3	-114.8	-78.6%	(\$116,085)
12 Tomah		48	24	38.5	10.9	-27.6	-71.7%	(\$27,887)
15 Topeka		112	72	107.9	28.1	-79.8	-74.0%	(\$80,697)
16 Gulf Coast		61	25	100.5	58.8	-41.7	-41.5%	(\$42,138)
16 Houston		64	46	58.6	26.0	-32.5	-55.5%	(\$32,901)
16 Little Rock		49	34	97.6	85.9	-11.7	-12.0%	(\$11,805)
16 New Orleans		58	23	30.9	28.8	-2.1	-6.8%	(\$2,110)
17 Dallas		73	51	80.0	25.1	-54.9	-68.6%	(\$55,466)
17 Temple (Waco)		65	57	102.6	34.6	-68.0	-66.2%	(\$68,748)
18 Phoenix		84	23	67.3	52.7	-14.6	-21.6%	(\$14,725)
19 Denver		74	58	91.2	51.9	-39.3	-43.1%	(\$39,760)
19 Grand Junction		48	31	28.6	28.6	0.0	0.1%	\$33

VISN	SITE	Total N FY02	1 N 730 Days	2 Pre-IDF MH Days/ Veteran	3 Post-IDF MH Days/ Veteran	4 Change MH Days/ Veteran (col 3-2)	5 % Change MH Days/ (4/2)	6 Change MH Cost*/ Inp't Veteran (4x\$1011)
19	Salt Lake City	56	47	67.7	20.0	-47.6	-70.4%	(\$48,141)
19	Sheridan	18	11	84.4	25.2	-59.2	-70.2%	(\$59,833)
19	Southern Colorado	97	86	30.7	7.9	-22.8	-74.3%	(\$23,053)
20	American Lake	51	39	120.9	27.1	-93.8	-77.6%	(\$94,878)
20	Boise	42	32	45.3	19.8	-25.5	-56.3%	(\$25,812)
20	Portland	78	50	59.1	35.3	-23.7	-40.2%	(\$24,001)
20	Seattle	58	32	52.9	22.8	-30.2	-57.0%	(\$30,488)
21	Palo Alto	45	31	128.1	44.7	-83.4	-65.1%	(\$84,304)
21	San Francisco	48	37	64.4	13.2	-51.1	-79.5%	(\$51,698)
22	Greater Los Angeles	51	42	153.4	60.4	-93.0	-60.6%	(\$93,975)
23	Iowa City	50	16	67.7	65.5	-2.2	-3.2%	(\$2,212)
23	Knoxville	90	68	57.9	17.9	-40.0	-69.2%	(\$40,470)
23	Minneapolis	72	62	144.4	16.0	-128.4	-88.9%	(\$129,816)
23	St. Cloud	39	23	54.2	49.3	-5.0	-9.1%	(\$5,011)
ALL SITES		4495	2900	125.8	38.1	-87.7	-69.7%	(\$88,685)
SITE AVERAGE		69	45	112.9	38.2	-74.7	-56.3%	(\$75,494)
SITE STD. DEV.		29	21	87.3	18.7	79.2	25.5%	\$80,041

*FY 2004 National general psychiatry per diem=\$1011(NMHPMS).

Total N FY04=IDF3 Table <10/01/04 (including terminated)

Shaded values exceed one standard deviation from the mean in undesired direction. Bold /Underlined values represent positive outliers.

Source: VA automated Patient Treatment File FY04; NMHPMS FY04

TABLE 2-19. BRIEF PSYCHIATRIC RATING SCALE

Pre-Entry vs. Follow-up

VISN	SITE	1 Pre-Entry N	2 Pre-Entry Mean	3 Follow-up Mean (2 + 4)	4 Change at Follow-up	5 Percent Change (4 / 2)
1	Bedford	127	37.68	29.41	-8.27	-21.94%
1	Brockton	47	36.32	25.47	-10.85	-29.86%
1	Togus	25	34.20	24.39	-9.81	-28.70%
1	West Haven	28	39.85	38.51	-1.33	-3.35%
2	Albany	24	50.51	48.87	-1.64	-3.25%
2	Buffalo	60	42.61	36.55	-6.07	-14.24%
2	Canandaigua	55	40.60	42.24	1.64	4.05%
2	Syracuse	42	43.38	45.31	1.93	4.45%
3	Brooklyn	57	41.52	37.66	-3.87	-9.31%
3	Montrose	67	46.59	46.56	-0.04	-0.08%
3	New Jersey	84	39.77	33.02	-6.75	-16.97%
3	Northport	30	43.03	49.26	6.23	14.48%
4	Coatesville	99	42.81	37.75	-5.06	-11.82%
4	Pittsburgh	133	34.78	25.57	-9.22	-26.50%
5	Martinsburg	31	35.35	23.78	-11.57	-32.73%
5	Perry Point	91	46.24	41.14	-5.11	-11.04%
6	Fayetteville	26	43.88	37.58	-6.31	-14.38%
6	Hampton	34	43.35	37.91	-5.45	-12.56%
6	Salem	34	37.03	28.84	-8.19	-22.12%
6	Salisbury	34	48.12	52.17	4.05	8.42%
7	Atlanta	40	35.06	17.10	-17.96	-51.22%
7	Augusta	71	30.67	17.56	-13.11	-42.74%
7	Birmingham	24	39.19	30.75	-8.43	-21.52%
7	Tuscaloosa	47	28.16	26.41	-1.74	-6.19%
7	Tuskegee	46	38.11	24.86	-13.24	-34.75%
8	Gainesville	62	48.60	35.60	-13.00	-26.75%
8	Miami	18	36.72	29.21	-7.51	-20.45%
8	Tampa	22	43.68	35.57	-8.11	-18.57%
10	Chillicothe	55	34.24	28.20	-6.04	-17.64%
10	Cincinnati	115	38.17	36.31	-1.86	-4.88%
10	Cleveland	166	37.21	32.99	-4.22	-11.34%
10	Columbus	26	35.49	22.49	-13.00	-36.64%
10	Dayton	107	37.80	30.27	-7.53	-19.92%
10	Youngstown	43	39.38	24.52	-14.86	-37.74%
11	Ann Arbor	54	42.87	33.56	-9.31	-21.71%
11	Battle Creek	69	37.26	32.41	-4.85	-13.03%
11	Detroit	89	33.46	21.50	-11.96	-35.75%
11	Northern Indiana	41	39.93	33.75	-6.18	-15.48%
12	Chicago-West Side	54	39.35	26.52	-12.84	-32.62%
12	Madison	48	36.91	35.07	-1.84	-4.99%
12	Milwaukee	33	53.80	62.50	8.70	16.18%
12	North Chicago	113	33.57	26.19	-7.38	-21.97%
12	Tomah	21	44.29	40.64	-3.64	-8.23%
15	St. Louis	52	62.56	61.42	-1.14	-1.82%
15	Topeka	39	45.10	42.99	-2.12	-4.69%
16	Gulf Coast	60	37.23	32.80	-4.43	-11.90%
16	Houston	64	42.00	36.95	-5.05	-12.01%
16	Little Rock	45	38.20	23.93	-14.27	-37.36%
16	New Orleans	54	47.78	43.69	-4.09	-8.56%
17	Dallas	73	36.87	29.01	-7.87	-21.33%
17	Temple (Waco)	64	43.75	38.78	-4.97	-11.35%
18	Albuquerque	63	35.51	35.62	0.11	0.32%
18	Phoenix	51	47.04	44.72	-2.32	-4.93%

VISN	SITE	1 Pre-Entry N	2 Pre-Entry Mean	3 Follow-up Mean (2 + 4)	4 Change at Follow-up	5 Percent Change (4 / 2)
19	Denver	73	36.53	32.57	-3.95	-10.82%
19	Grand Junction	47	58.23	48.63	-9.60	-16.49%
19	Salt Lake City	54	54.27	56.94	2.67	4.93%
19	Sheridan	17	53.06	75.17	22.11	41.67%
19	Southern Colorado	95	32.81	20.38	-12.43	-37.87%
20	American Lake	49	46.41	51.84	5.44	11.71%
20	Boise	41	37.17	33.77	-3.40	-9.16%
20	Portland	56	38.98	34.69	-4.29	-11.00%
20	Seattle	56	54.45	64.86	10.41	19.12%
21	Palo Alto	43	47.77	31.68	-16.08	-33.67%
21	San Francisco	46	44.23	42.50	-1.73	-3.91%
22	Greater Los Angeles	48	46.02	42.26	-3.76	-8.18%
22	San Diego	48	43.96	35.79	-8.17	-18.59%
23	Iowa City	48	39.67	34.81	-4.86	-12.25%
23	Knoxville	90	37.81	25.94	-11.87	-31.40%
23	Minneapolis	71	45.84	53.34	7.51	16.38%
23	Omaha	39	36.21	24.26	-11.94	-32.99%
23	St. Cloud	37	45.62	44.19	-1.43	-3.14%
	ALL SITES	4015	40.63	34.88	-5.64	-13.89%
	SITE AVERAGE	56.55	41.50	36.47	-5.03	-13.59%
	SITE STD DEVIATION	29.01	6.51	11.50	6.76	16.46%

Change values are least squares means derived from analysis of covariance adjusted for site, time, baseline value, and eleven other baseline covariates

Shaded values represent significant t-test differences, in the undesired direction, between LS means for the indicated site and the median site on this variable.

Bold Underlined values represent positive outliers.

Source: Client Interviews

TABLE 2-20. SYMPTOM SEVERITY (BSI GLOBAL SCALE)

Pre-Entry vs. Follow-up

VISN	SITE	1 Pre-Entry N	2 Pre-Entry Mean	3 Follow-up Mean (2 + 4)	4 Change at Follow-up	5 Percent Change (4 / 2)
1	Bedford	128	2.00	1.54	-0.46	-23.01%
1	Brockton	44	1.58	1.39	-0.19	-12.13%
1	Togus	24	1.77	1.33	-0.44	-24.88%
1	West Haven	28	2.14	2.18	0.04	2.01%
2	Albany	24	2.05	1.98	-0.07	-3.53%
2	Buffalo	60	2.20	2.11	-0.08	-3.78%
2	Canandaigua	54	1.93	1.67	-0.26	-13.30%
2	Syracuse	42	2.28	2.28	0.00	-0.01%
3	Brooklyn	57	2.11	1.89	-0.22	-10.49%
3	Montrose	61	1.99	1.67	-0.32	-16.23%
3	New Jersey	82	2.04	1.74	-0.30	-14.72%
3	Northport	28	1.99	2.09	0.10	5.09%
4	Coatesville	96	2.01	1.81	-0.20	-9.79%
4	Pittsburgh	123	1.70	1.32	-0.38	-22.20%
5	Martinsburg	30	2.28	2.24	-0.04	-1.63%
5	Perry Point	74	1.70	1.34	-0.36	-21.31%
6	Fayetteville	26	2.14	1.90	-0.24	-11.27%
6	Hampton	32	2.51	2.31	-0.21	-8.19%
6	Salem	32	1.96	1.74	-0.22	-11.16%
6	Salisbury	34	2.03	2.11	0.09	4.23%
7	Atlanta	40	2.17	1.81	-0.36	-16.47%
7	Augusta	71	1.87	1.71	-0.17	-8.83%
7	Birmingham	23	1.93	1.41	-0.52	-26.73%
7	Tuscaloosa	43	1.56	1.14	-0.41	-26.57%
7	Tuskegee	46	2.13	2.25	0.12	5.39%
8	Gainesville	62	2.15	1.82	-0.32	-15.00%
8	Miami	18	1.84	1.72	-0.12	-6.45%
8	Tampa	22	1.84	1.51	-0.33	-17.99%
10	Chillicothe	55	1.74	1.58	-0.17	-9.51%
10	Cincinnati	115	2.14	1.90	-0.24	-11.10%
10	Cleveland	156	1.81	1.61	-0.20	-11.32%
10	Columbus	25	2.29	2.24	-0.05	-2.19%
10	Dayton	106	2.02	1.75	-0.27	-13.17%
10	Youngstown	43	2.01	1.76	-0.25	-12.23%
11	Ann Arbor	53	2.05	1.76	-0.29	-14.14%
11	Battle Creek	65	1.90	1.81	-0.09	-4.71%
11	Detroit	88	1.87	1.59	-0.27	-14.67%
11	Northern Indiana	40	1.91	1.42	-0.49	-25.67%
12	Chicago-West Side	54	2.03	1.33	-0.70	-34.46%
12	Madison	48	1.88	1.80	-0.08	-4.45%
12	Milwaukee	33	2.05	2.10	0.05	2.61%
12	North Chicago	109	1.83	1.53	-0.30	-16.58%
12	Tomah	21	1.89	2.02	0.13	6.81%
15	St. Louis	51	2.60	2.43	-0.17	-6.64%
15	Topeka	38	2.34	2.11	-0.24	-10.08%
16	Gulf Coast	59	2.10	1.90	-0.20	-9.39%
16	Houston	62	2.22	1.90	-0.32	-14.58%
16	Little Rock	43	2.01	1.68	-0.33	-16.41%
16	New Orleans	47	2.20	1.93	-0.27	-12.47%
17	Dallas	71	2.08	1.99	-0.09	-4.52%
17	Temple (Waco)	63	2.19	2.31	0.13	5.91%
18	Albuquerque	62	2.10	2.00	-0.10	-4.97%
18	Phoenix	49	2.41	2.38	-0.04	-1.52%
19	Denver	72	1.96	1.75	-0.21	-10.80%
19	Grand Junction	47	2.54	2.17	-0.37	-14.66%
19	Salt Lake City	54	2.20	2.12	-0.07	-3.35%
19	Sheridan	17	2.29	2.86	0.57	25.12%

VISN	SITE	1 Pre-Entry N	2 Pre-Entry Mean	3 Follow-up Mean (2 + 4)	4 Change at Follow-up	5 Percent Change (4 / 2)
19	Southern Colorado	90	1.96	1.76	-0.19	-9.81%
20	American Lake	44	2.06	1.91	-0.15	-7.36%
20	Boise	40	2.12	1.85	-0.26	-12.43%
20	Portland	44	1.83	1.76	-0.08	-4.13%
20	Seattle	55	2.27	2.24	-0.04	-1.70%
21	Palo Alto	41	2.06	1.41	-0.65	-31.71%
21	San Francisco	45	2.06	2.02	-0.04	-1.93%
22	Greater Los Angeles	42	2.22	1.92	-0.30	-13.63%
22	San Diego	48	2.13	1.77	-0.36	-16.92%
23	Iowa City	48	2.02	1.77	-0.25	-12.41%
23	Knoxville	88	1.91	1.60	-0.32	-16.63%
23	Minneapolis	68	2.01	1.66	-0.35	-17.39%
23	Omaha	39	1.96	1.71	-0.25	-12.84%
23	St. Cloud	36	2.23	2.12	-0.12	-5.27%
	ALL SITES	3878	1.78	1.55	-0.23	-12.96%
	SITE AVERAGE	54.62	2.05	1.85	-0.20	-10.09%
	SITE STD DEVIATION	27.78	0.20	0.31	0.19	9.73%

Change values are least squares means derived from analysis of covariance adjusted for site, time, baseline value, and eleven other baseline covariates

Shaded values represent significant t-test differences, in the undesired direction, between LS means for the indicated site and the median site on this variable.

Bold/Underlined values represent positive outliers.

Source: Client Interviews

TABLE 2-21. GLOBAL ASSESSMENT OF FUNCTIONING

Pre-Entry vs. Follow-up

VISN	SITE	1 Pre-Entry N	2 Pre-Entry Mean	3 Follow-up Mean (2 + 4)	4 Change at Follow-up	5 Percent Change (4 / 2)
1	Bedford	127	40.79	40.27	-0.51	-1.26%
1	Brockton	47	31.55	25.33	-6.23	-19.73%
1	Togus	25	42.16	37.57	-4.59	-10.89%
1	West Haven	28	32.11	27.35	-4.76	-14.82%
2	Albany	24	36.75	35.81	-0.94	-2.56%
2	Buffalo	60	35.98	28.69	-7.30	-20.27%
2	Canandaigua	55	34.00	27.03	-6.97	-20.50%
2	Syracuse	42	40.98	44.07	3.09	7.55%
3	Brooklyn	57	41.02	45.40	4.38	10.68%
3	Montrose	67	39.66	36.79	-2.86	-7.22%
3	New Jersey	83	43.46	44.93	1.47	3.39%
3	Northport	29	44.24	48.73	4.49	10.15%
4	Coatesville	99	39.35	44.00	4.64	11.79%
4	Pittsburgh	131	38.27	41.70	3.43	8.96%
5	Martinsburg	31	44.90	50.04	5.13	11.43%
5	Perry Point	91	39.31	37.35	-1.96	-4.99%
6	Fayetteville	26	46.23	55.28	9.05	19.57%
6	Hampton	34	39.94	49.40	9.45	23.67%
6	Salem	34	46.32	54.95	8.63	18.63%
6	Salisbury	34	39.29	41.34	2.04	5.20%
7	Atlanta	40	45.55	54.41	8.86	19.46%
7	Augusta	71	43.11	50.51	7.39	17.15%
7	Birmingham	24	45.17	58.64	13.47	29.83%
7	Tuscaloosa	47	42.64	45.90	3.26	7.64%
7	Tuskegee	46	47.98	53.03	5.06	10.54%
8	Gainesville	62	42.18	42.55	0.37	0.87%
8	Miami	16	35.00	32.17	-2.83	-8.09%
8	Tampa	22	47.55	58.12	10.57	22.23%
10	Chillicothe	55	39.82	41.64	1.82	4.58%
10	Cincinnati	115	44.99	52.60	7.61	16.92%
10	Cleveland	166	36.63	36.41	-0.22	-0.60%
10	Columbus	26	45.88	57.03	11.14	24.29%
10	Dayton	106	46.44	49.17	2.73	5.87%
10	Youngstown	44	47.82	41.36	-6.46	-13.51%
11	Ann Arbor	54	35.87	33.77	-2.10	-5.86%
11	Battle Creek	69	47.30	52.42	5.12	10.82%
11	Detroit	89	43.58	51.17	7.59	17.41%
11	Northern Indiana	41	46.54	50.92	4.38	9.41%
12	Chicago-West Side	54	36.70	38.30	1.60	4.35%
12	Madison	48	43.67	43.62	-0.05	-0.11%
12	Milwaukee	33	42.82	46.95	4.13	9.65%
12	North Chicago	112	34.00	27.67	-6.33	-18.62%
12	Tomah	21	37.90	36.13	-1.78	-4.68%
15	St. Louis	47	40.40	48.19	7.79	19.27%
15	Topeka	39	39.67	39.38	-0.29	-0.73%
16	Gulf Coast	59	48.22	55.75	7.53	15.62%
16	Houston	63	40.16	43.55	3.39	8.43%
16	Little Rock	45	25.44	16.52	-8.92	-35.06%
16	New Orleans	50	35.70	33.69	-2.01	-5.62%
17	Dallas	73	39.33	37.51	-1.82	-4.63%
17	Temple (Waco)	64	39.03	43.73	4.70	12.05%
18	Albuquerque	63	38.11	40.22	2.10	5.52%

VISN	SITE	1 Pre-Entry N	2 Pre-Entry Mean	3 Follow-up Mean (2 + 4)	4 Change at Follow-up	5 Percent Change (4 / 2)
18	Phoenix	47	46.96	60.53	<u>13.57</u>	<u>28.90%</u>
19	Denver	73	37.33	41.53	4.20	11.25%
19	Grand Junction	47	34.96	34.25	-0.71	-2.04%
19	Salt Lake City	54	33.69	32.61	-1.07	-3.19%
19	Sheridan	17	48.76	57.05	<u>8.28</u>	<u>16.98%</u>
19	Southern Colorado	95	42.78	48.06	5.28	12.35%
20	American Lake	49	38.55	32.42	-6.13	-15.91%
20	Boise	41	39.98	35.65	-4.32	-10.81%
20	Portland	56	30.04	31.26	1.22	4.07%
20	Seattle	55	38.44	41.74	3.30	8.59%
21	Palo Alto	43	39.44	46.07	<u>6.62</u>	<u>16.79%</u>
21	San Francisco	47	37.40	44.42	<u>7.02</u>	<u>18.76%</u>
22	Greater Los Angeles	48	46.19	44.61	-1.58	-3.41%
22	San Diego	47	37.43	43.00	5.57	14.89%
23	Iowa City	48	28.17	32.73	4.56	16.19%
23	Knoxville	90	34.98	33.72	-1.25	-3.59%
23	Minneapolis	70	34.63	26.24	-8.39	-24.22%
23	Omaha	39	35.08	45.12	10.04	28.63%
23	St. Cloud	37	43.08	45.90	2.82	6.55%
	ALL SITES	3991	39.86	40.90	1.57	3.93%
	SITE AVERAGE	56.21	40.13	41.70	1.57	4.40%
	SITE STD DEVIATION	28.94	5.11	9.27	5.38	13.71%

Change values are least squares means derived from analysis of covariance adjusted for site, time, baseline value, and eleven other baseline covariates

Shaded values represent significant t-test differences, in the undesired direction, between LS means for the indicated site and the median site on this variable.

Bold/Underlined values represent positive outliers.

Source: Client Interviews

TABLE 2-22. INSTRUMENTAL ACTIVITIES OF DAILY LIVING

Pre-Entry vs. Follow-up

VISN	SITE	1 Pre-Entry N	2 Pre-Entry Mean	3 Follow-up Mean (2 + 4)	4 Change at Follow-up	5 Percent Change (4 / 2)
1	Bedford	123	47.38	52.70	5.32	11.23%
1	Brockton	36	45.59	45.60	0.00	0.00%
1	Togus	24	46.82	50.05	3.23	6.89%
1	West Haven	21	43.80	46.82	3.02	6.88%
2	Albany	22	46.15	52.24	6.09	13.20%
2	Buffalo	54	43.62	49.55	5.93	13.58%
2	Canandaigua	37	43.37	40.22	-3.15	-7.26%
2	Syracuse	41	43.69	43.70	0.01	0.03%
3	Brooklyn	55	43.85	45.78	1.93	4.41%
3	Montrose	31	32.33	28.27	-4.06	-12.55%
3	New Jersey	66	41.53	38.99	-2.54	-6.11%
3	Northport	27	40.23	40.32	0.08	0.21%
4	Coatesville	82	41.35	40.80	-0.55	-1.32%
4	Pittsburgh	128	46.78	48.94	2.17	4.63%
5	Martinsburg	30	47.63	52.39	4.76	10.00%
5	Perry Point	56	39.83	39.23	-0.60	-1.50%
6	Fayetteville	21	45.78	45.79	0.01	0.03%
6	Hampton	34	44.59	49.33	4.74	10.63%
6	Salem	26	51.39	58.66	7.27	14.15%
6	Salisbury	32	44.01	49.67	5.66	12.86%
7	Atlanta	36	44.78	46.60	1.82	4.07%
7	Augusta	47	43.31	42.89	-0.42	-0.97%
7	Birmingham	22	47.29	45.89	-1.40	-2.95%
7	Tuscaloosa	32	39.78	39.65	-0.12	-0.31%
7	Tuskegee	45	39.89	40.07	0.19	0.47%
8	Gainesville	51	42.47	41.83	-0.64	-1.52%
8	Miami	17	43.19	44.22	1.03	2.39%
8	Tampa	20	44.96	46.45	1.49	3.31%
10	Chillicothe	27	49.15	56.00	6.85	13.94%
10	Cincinnati	113	47.01	50.07	3.07	6.52%
10	Cleveland	147	44.34	42.26	-2.08	-4.69%
10	Columbus	26	45.08	49.54	4.46	9.89%
10	Dayton	103	49.13	51.24	2.10	4.28%
10	Youngstown	35	45.11	47.67	2.56	5.68%
11	Ann Arbor	43	44.83	49.73	4.91	10.95%
11	Battle Creek	53	42.52	40.72	-1.80	-4.23%
11	Detroit	77	44.61	43.77	-0.85	-1.90%
11	Northern Indiana	36	43.93	42.85	-1.08	-2.46%
12	Chicago-West Side	53	42.45	47.75	5.30	12.49%
12	Madison	43	47.91	48.72	0.81	1.69%
12	Milwaukee	32	43.43	42.35	-1.08	-2.49%
12	North Chicago	78	46.15	52.30	6.15	13.33%
12	Tomah	17	50.51	50.76	0.25	0.49%
15	St. Louis	42	41.25	44.40	3.16	7.65%
15	Topeka	33	45.00	50.23	5.23	11.63%
16	Gulf Coast	60	46.22	48.31	2.10	4.54%
16	Houston	64	42.73	40.65	-2.08	-4.88%
16	Little Rock	33	38.02	37.98	-0.04	-0.11%
16	New Orleans	49	42.14	45.21	3.07	7.27%
17	Dallas	70	44.37	44.08	-0.29	-0.65%
17	Temple (Waco)	56	47.40	55.17	7.77	16.38%
18	Albuquerque	55	50.02	48.47	-1.55	-3.10%
18	Phoenix	44	47.40	45.50	-1.90	-4.00%

VISN	SITE	1 Pre-Entry N	2 Pre-Entry Mean	3 Follow-up Mean (2 + 4)	4 Change at Follow-up	5 Percent Change (4 / 2)
19	Denver	65	45.83	49.60	3.77	8.23%
19	Grand Junction	46	43.36	41.59	-1.76	-4.07%
19	Salt Lake City	54	46.27	49.55	3.28	7.08%
19	Sheridan	17	49.73	48.83	-0.90	-1.81%
19	Southern Colorado	57	44.58	47.54	2.95	6.63%
20	American Lake	44	44.24	46.74	2.49	5.63%
20	Boise	40	47.21	46.98	-0.23	-0.49%
20	Portland	46	41.34	42.99	1.65	3.99%
20	Seattle	55	40.67	42.65	1.98	4.86%
21	Palo Alto	42	34.17	33.08	-1.08	-3.17%
21	San Francisco	41	43.18	42.84	-0.33	-0.77%
22	Greater Los Angeles	43	41.89	45.25	3.36	8.03%
22	San Diego	43	44.93	50.34	5.41	12.04%
23	Iowa City	46	46.93	44.89	-2.04	-4.35%
23	Knoxville	84	45.11	48.32	3.21	7.11%
23	Minneapolis	56	44.72	47.88	3.15	7.05%
23	Omaha	39	44.46	45.53	1.07	2.41%
23	St. Cloud	27	47.48	50.11	2.63	5.54%
	ALL SITES	3450	44.50	45.64	1.43	3.21%
	SITE AVERAGE	48.59	44.40	46.02	1.62	3.47%
	SITE STD DEVIATION	26.15	3.31	5.06	2.80	6.27%

Change values are least squares means derived from analysis of covariance adjusted for site, time, baseline value, and eleven other baseline covariates

Shaded values represent significant t-test differences, in the undesired direction, between LS means for the indicated site and the median site on this variable.

Bold/Underlined values represent positive outliers.

Source: Client Interviews

TABLE 2-23. QUALITY OF LIFE

Pre-Entry vs. Follow-up

VISN	SITE	1 Pre-Entry N	2 Pre-Entry Mean	3 Follow-up Mean (2 + 4)	4 Change at Follow-up	5 Percent Change (4 / 2)
1	Bedford	121	25.63	29.57	3.93	15.34%
1	Brockton	41	28.52	31.68	3.16	11.08%
1	Togus	24	26.87	30.50	3.64	13.54%
1	West Haven	28	23.08	23.96	0.88	3.80%
2	Albany	19	25.17	28.85	3.68	14.63%
2	Buffalo	56	25.69	28.67	2.98	11.60%
2	Canandaigua	49	27.09	30.36	3.26	12.04%
2	Syracuse	40	23.92	24.37	0.45	1.88%
3	Brooklyn	56	25.49	27.11	1.62	6.37%
3	Montrose	63	25.06	26.44	1.38	5.51%
3	New Jersey	76	25.09	26.79	1.70	6.78%
3	Northport	25	24.62	25.29	0.67	2.71%
4	Coatesville	89	25.09	26.87	1.77	7.06%
4	Pittsburgh	115	27.19	30.06	2.87	10.56%
5	Martinsburg	26	26.08	28.04	1.96	7.51%
5	Perry Point	80	28.27	31.30	3.03	10.74%
6	Fayetteville	22	25.36	29.45	4.09	16.12%
6	Hampton	30	25.28	30.11	4.83	19.09%
6	Salem	30	26.00	28.23	2.23	8.58%
6	Salisbury	31	25.88	30.05	4.17	16.10%
7	Atlanta	37	26.82	32.10	5.27	19.66%
7	Augusta	69	27.23	30.29	3.06	11.23%
7	Birmingham	20	28.02	31.75	3.73	13.32%
7	Tuscaloosa	41	28.85	30.99	2.14	7.41%
7	Tuskegee	46	27.17	30.99	3.83	14.09%
8	Gainesville	60	25.69	28.75	3.06	11.89%
8	Miami	14	26.74	28.03	1.29	4.83%
8	Tampa	19	27.77	30.13	2.36	8.50%
10	Chillicothe	54	26.17	30.44	4.27	16.32%
10	Cincinnati	97	25.39	27.47	2.08	8.19%
10	Cleveland	138	26.97	29.53	2.56	9.51%
10	Columbus	25	26.94	29.00	2.05	7.61%
10	Dayton	98	26.02	28.68	2.66	10.23%
10	Youngstown	38	27.00	30.89	3.89	14.41%
11	Ann Arbor	50	25.59	29.02	3.43	13.39%
11	Battle Creek	61	27.17	28.49	1.32	4.86%
11	Detroit	82	27.52	30.23	2.71	9.86%
11	Northern Indiana	33	27.24	31.90	4.67	17.13%
12	Chicago-West Side	52	26.35	28.43	2.08	7.90%
12	Madison	42	27.06	29.62	2.56	9.47%
12	Milwaukee	29	26.86	29.37	2.51	9.35%
12	North Chicago	111	25.56	28.36	2.80	10.95%
12	Tomah	17	26.68	28.46	1.78	6.67%
15	St. Louis	42	23.37	28.34	4.97	21.24%
15	Topeka	38	24.60	27.61	3.01	12.23%
16	Gulf Coast	53	26.51	28.76	2.24	8.46%
16	Houston	57	24.59	28.77	4.18	17.01%
16	Little Rock	42	24.66	26.52	1.86	7.56%
16	New Orleans	51	26.21	29.63	3.42	13.06%
17	Dallas	67	26.04	28.58	2.53	9.73%
17	Temple (Waco)	61	24.61	27.16	2.54	10.33%
18	Albuquerque	54	27.58	28.89	1.31	4.77%

VISN	SITE	1 Pre-Entry N	2 Pre-Entry Mean	3 Follow-up Mean (2 + 4)	4 Change at Follow-up	5 Percent Change (4 / 2)
18	Phoenix	39	25.29	24.55	-0.74	-2.94%
19	Denver	65	26.34	27.89	1.55	5.87%
19	Grand Junction	43	25.85	27.33	1.48	5.72%
19	Salt Lake City	50	25.70	26.35	0.64	2.50%
19	Sheridan	16	25.50	23.02	-2.48	-9.73%
19	Southern Colorado	80	27.30	29.38	2.07	7.60%
20	American Lake	48	25.46	27.54	2.08	8.17%
20	Boise	39	27.81	30.38	2.57	9.25%
20	Portland	39	25.07	28.67	3.60	14.36%
20	Seattle	52	23.66	24.96	1.30	5.48%
21	Palo Alto	38	24.13	28.20	4.07	16.88%
21	San Francisco	40	24.08	24.98	0.90	3.72%
22	Greater Los Angeles	45	23.27	24.72	1.45	6.25%
22	San Diego	41	25.29	28.92	3.63	14.35%
23	Iowa City	45	27.58	31.55	3.97	14.41%
23	Knoxville	80	26.25	29.53	3.27	12.47%
23	Minneapolis	69	26.25	26.57	0.32	1.21%
23	Omaha	37	27.60	31.77	4.17	15.11%
23	St. Cloud	33	26.00	29.80	3.80	14.61%
	ALL SITES	3618	26.08	28.99	2.61	10.00%
	SITE AVERAGE	50.96	26.04	28.60	2.57	9.82%
	SITE STD DEVIATION	25.97	1.28	2.06	1.37	5.31%

Change values are least squares means derived from analysis of covariance adjusted for site, time, baseline value, and eleven other baseline covariates

Shaded values represent significant t-test differences, in the undesired direction, between LS means for the indicated site and the median site on this variable.

Bold/Underlined values represent positive outliers.

Source: Client Interviews

TABLE 2-23a. HOUSING INDEPENDENCE

Pre-Entry vs. Follow-up

VISN	SITE	1 Pre-Entry N	2 Pre-Entry Mean	3 Follow-up Mean (2 + 4)	4 Change at Follow-up	5 Percent Change (4 / 2)
1	Bedford	126	2.72	3.21	0.50	18.23%
1	Brockton	47	2.49	2.97	0.48	19.31%
1	Togus	25	3.12	3.72	0.60	19.27%
1	West Haven	27	2.55	3.14	0.59	23.18%
2	Albany	24	3.07	3.60	0.53	17.23%
2	Buffalo	63	3.63	4.28	0.65	17.99%
2	Canandaigua	55	2.99	3.28	0.30	9.94%
2	Syracuse	42	3.24	3.91	0.67	20.61%
3	Brooklyn	57	3.56	4.26	0.70	19.59%
3	Montrose	67	2.24	2.47	0.22	10.02%
3	New Jersey	85	3.07	3.34	0.27	8.88%
3	Northport	29	2.27	2.21	-0.06	-2.54%
4	Coatesville	95	2.46	2.47	0.01	0.54%
4	Pittsburgh	125	3.22	3.91	0.69	21.44%
5	Martinsburg	31	3.19	3.12	-0.08	-2.37%
5	Perry Point	85	2.22	2.14	-0.07	-3.35%
6	Fayetteville	25	3.10	3.04	-0.06	-1.85%
6	Hampton	34	3.07	3.61	0.53	17.33%
6	Salem	34	2.97	3.55	0.58	19.46%
6	Salisbury	34	2.49	3.10	0.62	24.84%
7	Atlanta	40	3.31	4.10	0.79	23.90%
7	Augusta	70	2.35	2.65	0.31	13.03%
7	Birmingham	24	2.88	3.07	0.19	6.72%
7	Tuscaloosa	47	2.94	3.19	0.25	8.53%
7	Tuskegee	46	3.69	4.20	0.51	13.74%
8	Gainesville	61	3.29	3.50	0.21	6.39%
8	Miami	18	3.31	3.92	0.62	18.62%
8	Tampa	18	2.81	3.06	0.26	9.10%
10	Chillicothe	55	2.12	2.60	0.48	22.77%
10	Cincinnati	114	3.24	3.92	0.67	20.77%
10	Cleveland	164	3.08	3.54	0.46	14.91%
10	Columbus	25	3.28	4.07	0.79	23.96%
10	Dayton	104	3.63	4.34	0.71	19.54%
10	Youngstown	44	3.18	3.98	0.79	24.89%
11	Ann Arbor	54	3.25	3.77	0.51	15.80%
11	Battle Creek	69	2.84	3.11	0.27	9.66%
11	Detroit	89	2.76	3.14	0.38	13.93%
11	Northern Indiana	41	2.04	2.74	0.70	34.07%
12	Chicago-West Side	53	3.11	3.44	0.32	10.37%
12	Madison	48	2.78	3.53	0.75	26.94%
12	Milwaukee	33	3.61	4.40	0.79	21.80%
12	North Chicago	110	2.48	2.31	-0.17	-6.72%
12	Tomah	20	3.16	4.01	0.84	26.70%
15	St. Louis	50	2.84	3.25	0.42	14.66%
15	Topeka	39	2.77	3.26	0.49	17.62%
16	Gulf Coast	60	2.82	3.40	0.58	20.69%
16	Houston	64	3.01	3.46	0.45	15.05%
16	Little Rock	36	2.71	2.33	-0.39	-14.35%
16	New Orleans	55	2.88	3.48	0.61	21.14%
17	Dallas	73	3.43	4.08	0.65	19.06%
17	Temple (Waco)	64	3.08	3.73	0.66	21.42%
18	Albuquerque	63	3.44	3.83	0.39	11.29%
18	Phoenix	49	3.03	3.13	0.09	3.05%

VISN	SITE	1 Pre-Entry N	2 Pre-Entry Mean	3 Follow-up Mean (2 + 4)	4 Change at Follow-up	5 Percent Change (4 / 2)
19	Denver	73	2.97	3.01	0.04	1.42%
19	Grand Junction	46	3.28	3.70	0.42	12.82%
19	Salt Lake City	53	3.35	3.87	0.52	15.45%
19	Sheridan	17	3.38	4.29	0.91	<u>26.88%</u>
19	Southern Colorado	95	3.29	3.68	0.39	11.90%
20	American Lake	46	3.05	3.57	0.52	16.88%
20	Boise	39	3.30	3.49	0.18	5.50%
20	Portland	55	3.37	3.82	0.45	13.38%
20	Seattle	57	3.11	3.46	0.35	11.25%
21	Palo Alto	40	2.17	2.06	-0.11	-5.22%
21	San Francisco	47	2.91	3.35	0.43	14.81%
22	Greater Los Angeles	46	2.98	2.94	-0.04	-1.36%
22	San Diego	48	2.62	3.17	0.55	21.11%
23	Iowa City	48	3.47	3.93	0.47	13.43%
23	Knoxville	89	2.94	3.42	0.48	16.33%
23	Minneapolis	71	3.20	3.22	0.02	0.63%
23	Omaha	38	3.13	3.29	0.17	5.36%
23	St. Cloud	35	3.30	3.80	0.50	15.17%
	ALL SITES	3953	2.99	3.35	0.40	13.31%
	SITE AVERAGE	55.68	2.99	3.41	0.41	13.56%
	SITE STD DEVIATION	28.52	0.39	0.56	0.28	9.39%

Change values are least squares means derived from analysis of covariance adjusted for site, time, baseline value, and eleven other baseline covariates

Shaded values represent significant t-test differences, in the undesired direction, between LS means for the indicated site and the median site on this variable.

Bold/Underlined values represent positive outliers.

Source: Client Interviews

TABLE 2-24. VA MENTAL HEALTH SERVICE SATISFACTION

Pre-Entry vs. Follow-up

VISN	SITE	1 Pre-Entry N	2 Pre-Entry Mean	3 Follow-up Mean (2 + 4)	4 Change at Follow-up	5 Percent Change (4 / 2)
1	Bedford	122	9.57	10.80	1.23	12.90%
1	Brockton	42	9.29	10.46	1.17	12.64%
1	Togus	22	8.73	9.78	1.05	12.08%
1	West Haven	25	7.72	8.66	0.94	12.23%
2	Albany	23	10.65	11.56	0.91	8.56%
2	Buffalo	51	10.22	11.44	1.22	11.99%
2	Canandaigua	51	9.78	10.06	0.28	2.84%
2	Syracuse	41	9.68	10.36	0.67	6.97%
3	Brooklyn	49	8.96	10.24	1.28	14.29%
3	Montrose	59	8.75	8.81	0.07	0.79%
3	New Jersey	83	8.99	10.09	1.10	12.28%
3	Northport	26	8.92	9.15	0.22	2.52%
4	Coatesville	85	8.81	9.63	0.82	9.30%
4	Pittsburgh	121	9.44	9.72	0.28	2.96%
5	Martinsburg	29	10.66	11.40	0.74	6.97%
5	Perry Point	71	9.39	10.40	1.00	10.68%
6	Fayetteville	26	9.27	10.05	0.79	8.48%
6	Hampton	30	10.17	12.07	1.90	18.68%
6	Salem	32	9.22	10.06	0.84	9.09%
6	Salisbury	32	9.78	10.61	0.83	8.44%
7	Atlanta	37	9.03	11.02	1.99	22.08%
7	Augusta	68	9.09	9.44	0.35	3.89%
7	Birmingham	23	9.96	10.74	0.78	7.86%
7	Tuscaloosa	40	9.78	10.87	1.09	11.19%
7	Tuskegee	45	9.78	10.42	0.64	6.54%
8	Gainesville	59	8.12	9.96	1.84	22.70%
8	Miami	18	10.39	11.35	0.96	9.27%
8	Tampa	16	10.06	11.57	1.51	14.97%
10	Chillicothe	54	7.76	8.80	1.04	13.46%
10	Cincinnati	103	10.71	11.61	0.90	8.39%
10	Cleveland	147	9.95	10.98	1.02	10.29%
10	Columbus	25	9.20	10.16	0.96	10.40%
10	Dayton	99	9.98	10.75	0.77	7.69%
10	Youngstown	41	10.22	11.28	1.06	10.38%
11	Ann Arbor	43	8.51	9.72	1.21	14.25%
11	Battle Creek	60	8.87	8.77	-0.10	-1.11%
11	Detroit	80	10.18	10.62	0.44	4.34%
11	Northern Indiana	36	9.42	9.98	0.56	6.00%
12	Chicago-West Side	52	9.23	9.65	0.42	4.52%
12	Madison	43	9.63	10.27	0.64	6.69%
12	Milwaukee	33	10.33	11.39	1.06	10.26%
12	North Chicago	102	9.30	10.33	1.03	11.05%
12	Tomah	21	10.00	9.56	-0.44	-4.39%
15	St. Louis	45	9.44	11.04	1.59	16.87%
15	Topeka	34	9.85	11.08	1.23	12.44%
16	Gulf Coast	58	9.84	10.44	0.60	6.08%
16	Houston	58	10.19	11.35	1.16	11.41%
16	Little Rock	42	9.57	10.44	0.87	9.06%
16	New Orleans	40	10.08	11.67	1.60	15.84%
17	Dallas	69	9.23	10.14	0.90	9.79%
17	Temple (Waco)	62	8.66	8.67	0.01	0.08%
18	Albuquerque	59	10.22	10.57	0.35	3.41%
18	Phoenix	47	10.06	10.42	0.35	3.51%
19	Denver	68	8.76	9.59	0.83	9.43%

VISN	SITE	1 Pre-Entry N	2 Pre-Entry Mean	3 Follow-up Mean (2 + 4)	4 Change at Follow-up	5 Percent Change (4 / 2)
19	Grand Junction	44	11.16	12.21	1.05	9.38%
19	Salt Lake City	51	9.39	9.80	0.41	4.40%
19	Sheridan	17	10.47	12.14	1.67	15.94%
19	Southern Colorado	78	10.35	11.34	1.00	9.65%
20	American Lake	40	8.95	9.51	0.56	6.31%
20	Boise	40	9.20	10.47	1.27	13.83%
20	Portland	43	9.98	10.87	0.90	9.00%
20	Seattle	52	9.50	10.30	0.80	8.40%
21	Palo Alto	38	9.50	10.13	0.63	6.66%
21	San Francisco	41	9.12	9.05	-0.07	-0.78%
22	Greater Los Angeles	41	8.61	9.81	1.20	13.95%
22	San Diego	47	10.34	12.24	1.90	18.36%
23	Iowa City	45	9.82	11.05	1.22	12.46%
23	Knoxville	85	9.72	10.35	0.63	6.52%
23	Minneapolis	63	8.35	8.85	0.50	5.98%
23	Omaha	37	9.89	10.42	0.53	5.34%
23	St. Cloud	34	9.65	11.13	1.48	15.36%
ALL SITES		3643	9.53	10.34	0.85	8.95%
SITE AVERAGE		51.31	9.54	10.42	0.88	9.21%
SITE STD DEVIATION		26.12	0.69	0.89	0.49	5.19%

Change values are least squares means derived from analysis of covariance adjusted for site, time, baseline value, and eleven other baseline covariate

Shaded values represent significant t-test differences, in the undesired direction, between LS means for the indicated site and the median site on this variable.

Bold/Underlined values represent positive outliers.

Source: Client Interviews

TABLE 2-25. SATISFACTION WITH VA MHICM SERVICES

Pre-Entry vs. Follow-up

VISN	SITE	1 Pre-Entry N	2 Pre-Entry Mean	3 Follow-up Mean (2 + 4)	4 Change at Follow-up	5 Percent Change (4 / 2)
1	Bedford	123	3.01	3.62	0.61	20.32%
1	Brockton	43	3.07	3.35	0.28	9.05%
1	Togus	25	2.88	3.69	0.81	28.07%
1	West Haven	26	2.19	2.53	0.33	15.26%
2	Albany	24	3.29	4.10	0.81	24.53%
2	Buffalo	53	3.38	4.01	0.63	18.73%
2	Canandaigua	53	3.13	3.66	0.53	17.00%
2	Syracuse	42	3.17	3.71	0.54	17.19%
3	Brooklyn	52	2.73	3.19	0.46	16.74%
3	Montrose	56	3.18	3.55	0.37	11.73%
3	New Jersey	81	3.11	3.65	0.54	17.25%
3	Northport	26	3.15	3.49	0.34	10.66%
4	Coatesville	93	3.08	3.67	0.60	19.48%
4	Pittsburgh	119	3.14	3.82	0.68	21.66%
5	Martinsburg	29	3.45	4.24	0.79	22.82%
5	Perry Point	72	3.31	3.99	0.69	20.79%
6	Fayetteville	26	2.65	3.24	0.58	21.98%
6	Hampton	32	3.00	3.77	0.77	25.65%
6	Salem	32	3.25	4.02	0.77	23.83%
6	Salisbury	34	3.35	3.95	0.60	17.82%
7	Atlanta	38	2.92	3.55	0.63	21.49%
7	Augusta	65	3.42	4.08	0.67	19.50%
7	Birmingham	22	3.23	3.86	0.63	19.53%
7	Tuscaloosa	44	3.27	3.73	0.46	14.00%
7	Tuskegee	45	3.36	4.11	0.75	22.47%
8	Gainesville	54	2.81	3.56	0.75	26.55%
8	Miami	17	3.35	4.23	0.88	26.25%
8	Tampa	19	3.32	3.95	0.64	19.20%
10	Chillicothe	53	2.87	3.55	0.69	23.89%
10	Cincinnati	107	3.47	4.03	0.56	16.20%
10	Cleveland	153	3.24	3.84	0.60	18.54%
10	Columbus	25	2.92	3.41	0.49	16.76%
10	Dayton	101	3.21	3.94	0.74	22.92%
10	Youngstown	42	3.50	4.20	0.70	20.04%
11	Ann Arbor	45	2.93	3.55	0.61	20.90%
11	Battle Creek	61	3.18	3.58	0.40	12.63%
11	Detroit	84	3.15	3.74	0.59	18.58%
11	Northern Indiana	38	2.97	3.26	0.29	9.76%
12	Chicago-West Side	54	3.44	4.13	0.69	19.91%
12	Madison	43	3.37	3.81	0.44	13.04%
12	Milwaukee	32	3.69	4.43	0.74	20.12%
12	North Chicago	107	3.14	3.77	0.63	20.06%
12	Tomah	21	3.48	3.70	0.22	6.45%
15	St. Louis	47	2.94	3.48	0.55	18.60%
15	Topeka	38	2.97	3.69	0.72	24.25%
16	Gulf Coast	59	2.88	3.65	0.77	26.64%
16	Houston	63	3.19	3.81	0.62	19.46%
16	Little Rock	42	2.95	3.48	0.53	17.83%
16	New Orleans	45	3.20	3.86	0.66	20.58%
17	Dallas	67	3.30	3.88	0.58	17.61%
17	Temple (Waco)	59	3.19	3.69	0.50	15.83%
18	Albuquerque	61	3.16	3.78	0.62	19.53%

VISN	SITE	1 Pre-Entry N	2 Pre-Entry Mean	3 Follow-up Mean (2 + 4)	4 Change at Follow-up	5 Percent Change (4 / 2)
18	Phoenix	47	3.26	3.77	0.51	15.77%
19	Denver	67	2.93	3.39	0.47	16.00%
19	Grand Junction	46	3.50	4.11	0.61	17.45%
19	Salt Lake City	53	3.17	3.72	0.55	17.35%
19	Sheridan	17	3.35	4.17	0.82	24.45%
19	Southern Colorado	88	3.27	3.97	0.70	21.28%
20	American Lake	43	3.00	3.63	0.63	21.08%
20	Boise	41	3.24	3.87	0.63	19.36%
20	Portland	49	2.76	3.13	0.38	13.66%
20	Seattle	51	3.20	3.66	0.47	14.63%
21	Palo Alto	43	2.53	3.11	0.57	22.60%
21	San Francisco	43	3.00	3.02	0.02	0.69%
22	Greater Los Angeles	42	2.83	3.36	0.53	18.66%
22	San Diego	47	3.57	4.33	0.76	21.15%
23	Iowa City	47	2.98	3.63	0.65	21.74%
23	Knoxville	85	2.99	3.63	0.64	21.46%
23	Minneapolis	70	2.99	3.65	0.67	22.30%
23	Omaha	38	3.47	4.05	0.57	16.53%
23	St. Cloud	35	3.29	4.15	0.87	26.40%
ALL SITES		3744	3.14	3.73	0.59	18.78%
SITE AVERAGE		52.73	3.14	3.73	0.59	18.90%
SITE STD DEVIATION		26.70	0.26	0.33	0.16	4.86%

Change values are least squares means derived from analysis of covariance adjusted for site, time, baseline value, and eleven other baseline covariate

Shaded values represent significant t-test differences, in the undesired direction, between LS means for the indicated site and the median site on this variable.

Bold/Underlined values represent positive outliers.

Source: Client Interviews

TABLE 2-26. MHICM UNIT COSTS(Based on FY 2004 Expenditures)

VISN	SITE	FY 04 TOTAL EXPENDIT.	TOTAL VETS	COST PER VETERAN	FY 04 P/S EXPEND.	FY 04		ADJUSTED TOTAL VISITS PER VET/YR	TOTAL VISITS PER SITE/YR	COST PER VISIT
						FILLED	COST			
						FTE	PER FTE			
1	Bedford	\$1,052,745	130	\$8,098	\$1,026,711	13.00	\$78,978	108.70	14131	\$74
1	Brockton	\$429,964	79	\$5,443	\$429,964	5.93	\$72,507	45.35	3583	\$120
1	Togus	\$282,440	27	\$10,461	\$273,299	3.30	\$82,818	55.67	1503	\$188
1	West Haven	\$504,200	62	\$8,132	\$478,662	5.83	\$82,103	80.03	4962	\$102
2	Albany	\$376,263	49	\$7,679	\$375,475	4.85	\$77,418	97.74	4789	\$79
2	Buffalo	\$463,657	83	\$5,586	\$453,328	7.60	\$59,648	48.90	4058	\$114
2	Canandaigua	\$660,304	101	\$6,538	\$630,031	9.80	\$64,289	88.85	8974	\$74
2	Syracuse	\$224,012	53	\$4,227	\$224,012	3.75	\$59,737	40.40	2141	\$105
3	Brooklyn	\$373,812	58	\$6,445	\$360,845	4.40	\$82,010	37.28	2162	\$173
3	Montrose	\$894,773	102	\$8,772	\$882,690	8.60	\$102,638	59.14	6032	\$148
3	New Jersey	\$776,498	89	\$8,725	\$752,623	8.90	\$84,564	49.88	4439	\$175
3	Northport	\$656,771	103	\$6,376	\$627,687	6.90	\$90,969	61.92	6378	\$103
4	Coatesville	\$407,421	101	\$4,034	\$402,444	6.20	\$64,910	61.51	6212	\$66
4	Pittsburgh	\$648,253	136	\$4,767	\$644,663	9.10	\$70,842	40.70	5535	\$117
5	Martinsburg	\$196,860	33	\$5,965	\$196,691	3.00	\$65,564	51.74	1707	\$115
5	Perry Point	\$497,577	91	\$5,468	\$480,753	6.00	\$80,126	52.43	4772	\$104
6	Fayetteville	\$347,311	27	\$12,863	\$334,730	4.10	\$81,641	81.07	2189	\$159
6	Hampton	\$409,316	59	\$6,938	\$388,671	4.30	\$90,389	90.71	5352	\$76
6	Salem	\$375,416	44	\$8,532	\$369,888	4.00	\$92,472	47.59	2094	\$179
6	Salisbury	\$286,815	38	\$7,548	\$280,215	3.20	\$87,567	71.70	2724	\$105
7	Atlanta	\$545,184	61	\$8,937	\$528,930	6.20	\$85,311	87.26	5323	\$102
7	Augusta	\$265,309	71	\$3,737	\$263,809	2.75	\$95,931	53.06	3767	\$70
7	Birmingham	\$227,434	25	\$9,097	\$219,081	4.50	\$48,685	105.33	2633	\$86
7	Tuscaloosa	\$569,824	69	\$8,258	\$547,782	8.10	\$67,627	83.80	5782	\$99
7	Tuskegee	\$401,994	52	\$7,731	\$378,714	5.00	\$75,743	75.07	3904	\$103
8	Gainesville	\$399,728	62	\$6,447	\$352,507	6.20	\$56,856	71.38	4425	\$90
8	Miami	\$735,032	53	\$13,869	\$715,383	4.25	\$168,325	76.19	4038	\$182
8	Tampa	\$326,827	52	\$6,285	\$310,010	5.00	\$62,002	58.11	3022	\$108
10	Chillicothe	\$649,793	73	\$8,901	\$630,582	7.10	\$88,814	62.73	4579	\$142
10	Cincinnati	\$614,957	116	\$5,301	\$523,232	9.30	\$56,262	53.84	6245	\$98
10	Cleveland	\$1,466,504	169	\$8,678	\$1,423,674	15.00	\$94,912	77.86	13158	\$111
10	Columbus	\$259,007	27	\$9,593	\$242,247	2.66	\$91,070	50.40	1361	\$190
10	Dayton	\$728,138	110	\$6,619	\$619,232	10.50	\$58,974	59.24	6517	\$112
10	Youngstown	\$431,987	45	\$9,600	\$420,907	3.85	\$109,326	78.46	3531	\$122
11	Ann Arbor	\$397,927	54	\$7,369	\$355,355	5.20	\$68,338	82.54	4457	\$89
11	Battle Creek	\$443,563	72	\$6,161	\$423,053	5.20	\$81,356	60.86	4382	\$101
11	Detroit	\$461,163	94	\$4,906	\$454,663	7.92	\$57,407	35.67	3353	\$138
11	Northern Indiana	\$597,220	82	\$7,283	\$528,810	7.80	\$67,796	86.64	7105	\$84
12	Chicago-West Side	\$427,109	70	\$6,102	\$427,109	6.25	\$68,337	73.31	5132	\$83
12	Madison	\$451,244	49	\$9,209	\$406,843	4.63	\$87,871	151.68	7432	\$61
12	Milwaukee	\$362,879	33	\$10,996	\$343,853	4.95	\$69,465	85.61	2825	\$128
12	North Chicago	\$927,644	118	\$7,861	\$899,219	10.50	\$85,640	112.60	13286	\$70
12	Tomah	\$295,050	48	\$6,147	\$288,437	3.85	\$74,919	141.02	6769	\$44
15	St. Louis	\$357,953	54	\$6,629	\$337,732	3.00	\$112,577	68.32	3689	\$97
15	Topeka	\$650,070	112	\$5,804	\$650,070	9.00	\$72,230	135.21	15143	\$43
16	Gulf Coast	\$392,766	61	\$6,439	\$387,229	5.70	\$67,935	61.65	3761	\$104
16	Houston	\$560,369	64	\$8,756	\$540,933	5.50	\$98,351	48.77	3121	\$180
16	Little Rock	\$424,473	49	\$8,663	\$415,794	5.00	\$83,159	83.49	4091	\$104
16	New Orleans	\$437,369	58	\$7,541	\$427,775	4.88	\$87,659	43.08	2499	\$175
17	Dallas	\$554,434	73	\$7,595	\$533,666	8.00	\$66,708	79.95	5836	\$95
17	Temple (Waco)	\$337,964	65	\$5,199	\$304,763	5.00	\$60,953	89.85	5841	\$58

VISN	SITE	FY 04 TOTAL EXPENDIT.	TOTAL VETS	COST PER VETERAN	FY 04 P/S EXPEND.	FY 04		ADJUSTED TOTAL VISITS PER VET/YR	TOTAL VISITS PER SITE/YR	COST PER VISIT
						FILLED	COST PER FTE			
18	Albuquerque	\$493,183	64	\$7,706	\$468,253	7.00	\$66,893	113.50	7264	\$68
18	Phoenix	\$432,263	84	\$5,146	\$416,084	5.60	\$74,301	39.20	3293	\$131
19	Denver	\$455,584	74	\$6,157	\$454,387	6.50	\$69,906	54.39	4025	\$113
19	Grand Junction	\$207,120	48	\$4,315	\$202,920	4.00	\$50,730	70.42	3380	\$61
19	Salt Lake City	\$376,675	56	\$6,726	\$364,756	4.75	\$76,791	53.15	2977	\$127
19	Sheridan	\$132,532	18	\$7,363	\$118,187	1.50	\$78,791	43.23	778	\$170
19	Southern Colorado	\$586,792	97	\$6,049	\$493,716	6.25	\$78,995	63.33	6143	\$96
20	American Lake	\$369,394	51	\$7,243	\$368,094	4.90	\$75,121	57.48	2932	\$126
20	Boise	\$294,219	42	\$7,005	\$269,903	4.10	\$65,830	27.69	1163	\$253
20	Portland	\$650,101	78	\$8,335	\$629,520	6.80	\$92,576	79.35	6189	\$105
20	Seattle	\$246,536	58	\$4,251	\$245,236	4.10	\$59,814	69.79	4048	\$61
21	Palo Alto	\$458,456	45	\$10,188	\$450,056	3.20	\$140,643	48.40	2178	\$211
21	San Francisco	\$434,855	48	\$9,059	\$412,335	3.70	\$111,442	66.34	3184	\$137
22	Greater Los Angeles	\$490,360	51	\$9,615	\$471,120	5.00	\$94,224	22.58	1152	\$426
22	San Diego	\$454,425	48	\$9,467	\$436,468	4.20	\$103,921	79.21	3802	\$120
23	Iowa City	\$398,657	50	\$7,973	\$359,280	5.30	\$67,789	50.22	2511	\$159
23	Knoxville	\$592,062	90	\$6,578	\$556,459	8.35	\$66,642	59.38	5344	\$111
23	Minneapolis	\$455,737	72	\$6,330	\$441,427	6.20	\$71,198	51.77	3727	\$122
23	Omaha	\$386,392	42	\$9,200	\$366,732	5.00	\$73,346	77.35	3249	\$119
23	St. Cloud	\$344,658	39	\$8,837	\$326,608	3.20	\$102,065	43.69	1704	\$202
ALL SITES		\$33,825,325	4761	\$7,105	\$31,924,662	415.20	\$76,890	69.22	329,554	\$103
SITE AVERAGE		\$476,413.01	67.06	\$7,406	\$455,864	5.85	\$79,757	68.66	4,645	\$121
SITE STD. DEV.		\$208,451.50	28.56	\$1,943	\$201,600	2.42	\$19,409	25.01	2,842	\$56

* Expenditures include space rental.

~MHICM teams(N=7) with insufficient data to be included in this Report: Philadelphia, Baltimore, Washington, DC, Columbia, Mountain Home, Danville and Fort Harrison.

Cleveland data are aggregated for three teams.

Excludes veterans treated by MHICM staff but receiving non-MHICM services.

Source: MHICM Local Progress Reports FY 2004

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TABLE 2-27. SITE PERFORMANCE ON MHICM CRITICAL MONITORS

						Total Team Outlier	Total Applicable Monitors	%Outliers/ Applicable Monitors							Total Team Outlier	Total Applicable Monitors	%Outliers/ Applicable Monitors							
VISN	SITE	STRUCTURE	CLIENT	PROCESS	OUTCOME				VISN	SITE	STRUCTURE	CLIENT	PROCESS	OUTCOME										
1	Bedford	0	0	0	1	1	17	5.9%	12	Madison	1	0	0	0	1	17	5.9%							
1	Brockton	1	0	1	0	2	17	11.8%	12	Milwaukee	2	1	1	2	6	17	35.3%							
1	Togus	1	0	0	0	1	17	5.9%	12	North Chicago	1	0	0	0	1	17	5.9%							
1	West Haven	2	0	0	0	2	17	11.8%	12	Tomah	1	0	1	0	2	17	11.8%							
2	Albany	3	0	0	0	3	17	17.6%	15	St. Louis	4	0	1	0	5	17	29.4%							
2	Buffalo	0	1	2	1	4	17	23.5%	15	Topeka	0	0	0	0	0	17	0.0%							
2	Canandaigua	1	0	0	1	2	17	11.8%	16	Gulf Coast	0	0	1	0	1	17	5.9%							
2	Syracuse	2	0	2	1	5	17	29.4%	16	Houston	0	1	1	0	2	17	11.8%							
3	Brooklyn	3	0	2	0	5	17	29.4%	16	Little Rock	0	0	0	1	1	17	5.9%							
3	Montrose	1	0	1	0	2	17	11.8%	16	New Orleans	1	0	1	1	3	17	17.6%							
3	New Jersey	0	0	1	0	1	17	5.9%	17	Dallas	1	0	1	0	2	17	11.8%							
3	Northport	1	0	0	1	2	17	11.8%	17	Temple (Waco)	1	0	1	0	2	17	11.8%							
4	Coatesville	1	0	0	0	1	17	5.9%	18	Albuquerque	1	0	0	0	1	17	5.9%							
4	Pittsburgh	1	0	2	0	3	17	17.6%	18	Phoenix	1	0	3	1	5	17	29.4%							
5	Martinsburg	3	0	2	0	5	17	29.4%	19	Denver	1	0	0	0	1	17	5.9%							
5	Perry Point	3	0	1	0	4	17	23.5%	19	Grand Junction	2	0	1	1	4	17	23.5%							
6	Fayetteville	1	1	2	0	4	17	23.5%	19	Salt Lake City	0	1	0	1	2	17	11.8%							
6	Hampton	0	0	1	0	1	17	5.9%	19	Sheridan	1	0	2	3	6	17	35.3%							
6	Salem	2	0	3	0	5	17	29.4%	19	Southern Colorado	1	1	0	0	2	17	11.8%							
6	Salisbury	2	0	1	1	4	17	23.5%	20	American Lake	0	0	0	1	1	17	5.9%							
7	Atlanta	1	0	1	0	2	17	11.8%	20	Boise	1	1	1	0	3	17	17.6%							
7	Augusta	4	0	0	0	4	17	23.5%	20	Portland	0	0	1	0	1	17	5.9%							
7	Birmingham	2	0	0	0	2	17	11.8%	20	Seattle	2	1	1	1	5	17	29.4%							
7	Tuscaloosa	2	0	0	0	2	17	11.8%	21	Palo Alto	2	0	2	0	4	17	23.5%							
7	Tuskegee	2	0	0	1	3	17	17.6%	21	San Francisco	1	0	2	0	3	17	17.6%							
8	Gainesville	2	0	0	0	2	17	11.8%	22	Greater Los Angeles	2	0	1	0	3	17	17.6%							
8	Miami	3	0	0	0	3	17	17.6%	22	San Diego	3	0	0	0	3	17	17.6%							
8	Tampa	2	0	1	0	3	17	17.6%	23	Iowa City	0	0	2	1	3	17	17.6%							
10	Chillicothe	0	0	0	0	0	17	0.0%	23	Knoxville	1	0	2	0	3	17	17.6%							
10	Cincinnati	0	1	1	1	3	17	17.6%	23	Minneapolis	0	0	1	1	2	17	11.8%							
10	Cleveland	0	0	0	0	0	17	0.0%	23	Omaha	2	0	1	0	3	17	17.6%							
10	Columbus	4	0	1	0	5	17	29.4%	23	St. Cloud	1	0	1	1	3	17	17.6%							
10	Dayton	2	1	0	1	4	17	23.5%	OUTLIER SITES(N)				53	11	42	21	67	1207	15.4%					
10	Youngstown	2	1	1	0	4	17	23.5%	OUTLIER SITES(%)				74.6%	15.5%	59.2%	29.6%	94.4%							
11	Ann Arbor	1	0	0	0	1	17	5.9%	OUTLIER TOTAL				92	11	59	24	186							
11	Battle Creek	2	0	1	0	3	17	17.6%	TOTAL MONITORS				355	213	355	284	1207	1207						
11	Detroit	0	0	3	0	3	17	17.6%	% OUTLIERS/TOTAL				25.9%	5.2%	16.6%	8.5%	15.4%							
11	Northern Indiana	1	0	0	0	1	17	5.9%	OUTLIER MEAN				1.30	0.15	0.83	0.34	2.62	17	15.4%					
12	Chicago-West Side	0	0	0	0	0	17	0.0%																

TABLE 2-28. OUTLIERS FOR TEAM STRUCTURE MONITORS

VISN	SITE	1 FTE UNFILLED MORE THAN 6 MONTHS (Y)	2 UNASSIGNED MEDICAL SUPPORT MD and/or RN (N)	3 CASELOAD SIZE MEAN RATIO OF CLIENTS PER CLINICAL FTEE (LT 7 or GT 15)	4 TEAM SIZE # FULL-TIME CLINICAL STAFF (4.0+ FTEE)	5 TOTAL TEAM STRUCTURE OUTLIERS (1+2+3+4)	6 # APPLICABLE TEAM STRUCTURE MONITORS (1+2+3+4)	7 % OUTLIERS/ APPLICABLE STRUCTURE MONITORS (5/6)
Outlier Direction								
1	Bedford					0	5	0%
1	Brockton		N			1	5	20%
1	Togus				2.70	1	5	20%
1	West Haven	Y	N			2	5	40%
2	Albany	Y		15.38	3.25	3	5	60%
2	Buffalo					0	5	0%
2	Canandaigua		N			1	5	20%
2	Syracuse		N		3.00	2	5	40%
3	Brooklyn	Y	N		3.90	3	5	60%
3	Montrose	Y				1	5	20%
3	New Jersey					0	5	0%
3	Northport		N			1	5	20%
4	Coatesville		N			1	5	20%
4	Pittsburgh			16.27		1	5	20%
5	Martinsburg	Y	N		3.00	3	5	60%
5	Perry Point	Y	N	15.06		3	5	60%
6	Fayetteville				3.40	1	5	20%
6	Hampton					0	5	0%
6	Salem	Y			3.00	2	5	40%
6	Salisbury	Y			2.50	2	5	40%
7	Atlanta	Y				1	5	20%
7	Augusta	Y	N	35.00	2.00	4	5	80%
7	Birmingham			6.29	3.50	2	5	40%
7	Tuscaloosa		N	15.75		2	5	40%
7	Tuskegee	Y	N			2	5	40%
8	Gainesville			16.00	3.50	2	5	40%
8	Miami	Y		21.20	2.50	3	5	60%
8	Tampa		N		3.50	2	5	40%
10	Chillicothe					0	5	0%
10	Cincinnati					0	5	0%
10	Cleveland					0	5	0%
10	Columbus	Y	N		2.33	4	5	80%
10	Dayton	Y	N			2	5	40%
10	Youngstown		N		3.10	2	5	40%
11	Ann Arbor				3.50	1	5	20%
11	Battle Creek	Y		15.50		2	5	40%
11	Detroit					0	5	0%
11	Northern Indiana	Y				1	5	20%
12	Chicago-West Side					0	5	0%
12	Madison				3.30	1	5	20%
12	Milwaukee			6.29	3.50	2	5	40%
12	North Chicago	Y				1	5	20%
12	Tomah				3.75	1	5	20%
15	St. Louis	Y	N	18.40	2.50	4	5	80%
15	Topeka					0	5	0%
16	Gulf Coast					0	5	0%
16	Houston					0	5	0%
16	Little Rock					0	5	0%

VISN	SITE	1 FTE UNFILLED MORE THAN 6 MONTHS (Y)	2 UNASSIGNED MEDICAL SUPPORT MD and/or RN (N)	3 CASELOAD SIZE MEAN RATIO OF CLIENTS PER CLINICAL FTEE (LT 7 or GT 15)	4 TEAM SIZE # FULL-TIME CLINICAL STAFF (4.0+ FTEE)	5 TOTAL TEAM STRUCTURE OUTLIERS (1+2+3+4)	6 # APPLICABLE TEAM STRUCTURE MONITORS (1+2+3+4)	7 % OUTLIERS/ APPLICABLE STRUCTURE MONITORS (5/6)
Outlier Direction								
16	New Orleans				3.50	1	5	20%
17	Dallas		N			1	5	20%
17	Temple (Waco)		N			1	5	20%
18	Albuquerque		N			1	5	20%
18	Phoenix		N			1	5	20%
19	Denver		N			1	5	20%
19	Grand Junction		N		3.50	2	5	40%
19	Salt Lake City					0	5	0%
19	Sheridan				1.20	1	5	20%
19	Southern Colorado		N			1	5	20%
20	American Lake					0	5	0%
20	Boise				3.00	1	5	20%
20	Portland					0	5	0%
20	Seattle	Y			3.45	2	5	40%
21	Palo Alto	Y			3.00	2	5	40%
21	San Francisco				3.00	1	5	20%
22	Greater Los Angeles		N		3.50	2	5	40%
22	San Diego	Y		17.20	2.50	3	5	60%
23	Iowa City					0	5	0%
23	Knoxville	Y				1	5	20%
23	Minneapolis					0	5	0%
23	Omaha		N		3.50	2	5	40%
23	St. Cloud				3.10	1	5	20%
OUTLIER SITES (N)		22	22	5	12	31	53	26%
OUTLIER SITES (%)		31.0%	31.0%	7.0%	16.9%	43.7%	74.6%	100%
OUTLIER TOTAL						92	355	26%

Outlier: Significant difference (p<0.05) from median site in undesired direction, after adjusting for client differences and time in program.

[Team structure monitors are presented in Report Tables 2-5 (p.35) and 2-6(36).]

TABLE 2-29. OUTLIERS FOR CLIENT CHARACTERISTICS MONITORS

VISN	Outlier Direction	1 PERCENT OF CLIENTS WITH GTE 30 DAYS HOSP. YR PRE (LT 50%)	2 PERCENT OF CLIENTS WITH PSYCHOTIC DX AT ENTRY. (LT 50%)	3 MEAN GAF AT ENTRY EXCEEDS 50 (GT 50)	4 Total Client Outliers (1+2+3)	5 # Applicable Client Characteristic Monitors (1+2+3)	6 % Outliers/ Applicable Client Monitors (4/5)
1 Bedford					0	3	0%
1 Brockton					0	3	0%
1 Togus					0	3	0%
1 West Haven					0	3	0%
2 Albany					0	3	0%
2 Buffalo		25.9			1	3	33%
2 Canandaigua					0	3	0%
2 Syracuse					0	3	0%
3 Brooklyn					0	3	0%
3 Montrose					0	3	0%
3 New Jersey					0	3	0%
3 Northport					0	3	0%
4 Coatesville					0	3	0%
4 Pittsburgh					0	3	0%
5 Martinsburg					0	3	0%
5 Perry Point					0	3	0%
6 Fayetteville		48.0			1	3	33%
6 Hampton					0	3	0%
6 Salem					0	3	0%
6 Salisbury					0	3	0%
7 Atlanta					0	3	0%
7 Augusta					0	3	0%
7 Birmingham					0	3	0%
7 Tuscaloosa					0	3	0%
7 Tuskegee					0	3	0%
8 Gainesville					0	3	0%
8 Miami					0	3	0%
8 Tampa					0	3	0%
10 Chillicothe					0	3	0%
10 Cincinnati		47.6			1	3	33%
10 Cleveland					0	3	0%
10 Columbus					0	3	0%
10 Dayton		39.6			1	3	33%
10 Youngstown		45.2			1	3	33%
11 Ann Arbor					0	3	0%
11 Battle Creek					0	3	0%
11 Detroit					0	3	0%
11 Northern Indiana					0	3	0%
12 Chicago-West Side					0	3	0%
12 Madison					0	3	0%
12 Milwaukee		30.0			1	3	33%
12 North Chicago					0	3	0%
12 Tomah					0	3	0%
15 St. Louis					0	3	0%
15 Topeka					0	3	0%
16 Gulf Coast					0	3	0%
16 Houston		47.6			1	3	33%
16 Little Rock					0	3	0%
16 New Orleans					0	3	0%
17 Dallas					0	3	0%

VISN	Outlier Direction	1 PERCENT OF CLIENTS WITH GTE 30 DAYS HOSP. YR PRE (LT 50%)	2 PERCENT OF CLIENTS WITH PSYCHOTIC DX AT ENTRY. (LT 50%)	3 MEAN GAF AT ENTRY EXCEEDS 50 (GT 50)	4 Total Client Outliers (1+2+3)	5 # Applicable Client Characteristic Monitors (1+2+3)	6 % Outliers/ Applicable Client Monitors (4/5)
17	Temple (Waco)				0	3	0%
18	Albuquerque				0	3	0%
18	Phoenix				0	3	0%
19	Denver				0	3	0%
19	Grand Junction				0	3	0%
19	Salt Lake City	42.6			1	3	33%
19	Sheridan				0	3	0%
19	Southern Colorado	22.3			1	3	33%
20	American Lake				0	3	0%
20	Boise	45.0			1	3	33%
20	Portland				0	3	0%
20	Seattle	42.9			1	3	33%
21	Palo Alto				0	3	0%
21	San Francisco				0	3	0%
22	Greater Los Angeles				0	3	0%
22	San Diego				0	3	0%
23	Iowa City				0	3	0%
23	Knoxville				0	3	0%
23	Minneapolis				0	3	0%
23	Omaha				0	3	0%
23	St. Cloud				0	3	0%
OUTLIER SITES (N)		11	0	0	11	213	5%
OUTLIER SITES (%)		15.5%	0.0%	0.0%	15.5%	100%	
OUTLIER TOTAL					11	213	5%

[Client monitors are presented in Report Tables 2-10 and 2-11.]

TABLE 2-30. OUTLIERS FOR CLINICAL PROCESS MONITORS

VISN	SITE	1 Tenure % Clients Discharged	2 Intensity % Clients Seen For GTE 1 Hour Per Week	3 Location % Clients Seen 60% Or More In Community	4 Frequency # Adjusted Face-Face Contacts/WK /Veteran	5 Team Provides Psychiatric Rehabilit'n Services	6 Total Clinical Process Outliers (1+2+3+4+5)	7 # Applicable Clinical Process Outliers (1+2+3+4+5)	8 % Outliers/ Applicable Clinical Process Monitors (6/7)
Outlier Direction		(>20%)	(<1HR/WK)	(<50%)	(<1/WK)	(<25% VETS)			
1	Bedford						0	5	0%
1	Brockton				0.87		1	5	20%
1	Togus						0	5	0%
1	West Haven						0	5	0%
2	Albany						0	5	0%
2	Buffalo				0.94	7.8	2	5	40%
2	Canandaigua						0	5	0%
2	Syracuse		47.2	45.3	0.78		2	5	40%
3	Brooklyn	22.4%			0.72		2	5	40%
3	Montrose		15.7				1	5	20%
3	New Jersey				0.96		1	5	20%
3	Northport						0	5	0%
4	Coatesville						0	5	0%
4	Pittsburgh		35.3		0.78		2	5	40%
5	Martinsburg	30.3%			0.99		2	5	40%
5	Perry Point	30.8%					1	5	20%
6	Fayetteville		48.1			21.7	2	5	40%
6	Hampton	23.7%					1	5	20%
6	Salem	27.3%			0.92	23.3	3	5	60%
6	Salisbury	23.7%					1	5	20%
7	Atlanta	27.9%					1	5	20%
7	Augusta						0	5	0%
7	Birmingham						0	5	0%
7	Tuscaloosa						0	5	0%
7	Tuskegee						0	5	0%
8	Gainesville						0	5	0%
8	Miami						0	5	0%
8	Tampa		32.7				1	5	20%
10	Chillicothe						0	5	0%
10	Cincinnati		47.4				1	5	20%
10	Cleveland						0	5	0%
10	Columbus				0.97		1	5	20%
10	Dayton						0	5	0%
10	Youngstown		42.2				1	5	20%
11	Ann Arbor						0	5	0%
11	Battle Creek		38.9				1	5	20%
11	Detroit		36.2		0.69	11.6	3	5	60%
11	Northern Indiana						0	5	0%
12	Chicago-West Side						0	5	0%
12	Madison						0	5	0%
12	Milwaukee	24.2%					1	5	20%
12	North Chicago						0	5	0%
12	Tomah					16.2	1	5	20%
15	St. Louis	20.4%					1	5	20%
15	Topeka						0	5	0%
16	Gulf Coast	36.1%					1	5	20%
16	Houston				0.94		1	5	20%
16	Little Rock						0	5	0%
16	New Orleans				0.83		1	5	20%

VISN	SITE	1 Tenure % Clients Discharged	2 Intensity % Clients Seen For GTE 1 Hour Per Week	3 Location % Clients Seen 60% Or More In Community	4 Frequency # Adjusted Face-Face Contacts/WK /Veteran	5 Team Provides Psychiatric Rehabilit'n Services	6 Total Clinical Process Outliers (1+2+3+4+5)	7 # Applicable Clinical Process Outliers (1+2+3+4+5)	8 % Outliers/ Applicable Clinical Process Monitors (6/7)
Outlier Direction		(>20%)	(<1HR/WK)	(<50%)	(<1/WK)	(<25% VETS)			
17	Dallas		30.1				1	5	20%
17	Temple (Waco)	32.3%					1	4	25%
18	Albuquerque						0	5	0%
18	Phoenix	21.4%			0.75	23.5	3	5	60%
19	Denver						0	5	0%
19	Grand Junction	20.8%					1	5	20%
19	Salt Lake City						0	5	0%
19	Sheridan	22.2%			0.83		2	5	40%
19	Southern Colorado						0	5	0%
20	American Lake						0	5	0%
20	Boise				0.53		1	5	20%
20	Portland	23.1%					1	5	20%
20	Seattle					20.0	1	5	20%
21	Palo Alto	24.4%			0.93		2	5	40%
21	San Francisco	22.9%	22.9				2	5	40%
22	Greater Los Angeles				0.43		1	5	20%
22	San Diego						0	5	0%
23	Iowa City		38.0		0.97		2	5	40%
23	Knoxville	22.2%	40.0				2	5	40%
23	Minneapolis				1.00		1	5	20%
23	Omaha		47.6				1	5	20%
23	St. Cloud				0.84		1	5	20%
OUTLIER SITES (N)		18	14	1	20	7	42	354	17%
OUTLIER SITES (%)		38%	29%	2%	42%	15%	88%	148%	
OUTLIER TOTAL							59	354	25%

[Clinical process monitors are presented in Report Tables 2-12, 2-13, 2-14, and 2-15.]

TABLE 2-31. OUTLIERS FOR CLIENT OUTCOME MONITORS

VISN	SITE	1 365 Days % Change MH Days (Post-Pre) (Low)	2 Reported Symptoms % Change (BSI) (HIGH)	3 Observed Symptoms % Change (BPRS) (HIGH)	4 Quality of Life % Change (QOL) (LOW)	5 Total Client Outcome Outliers (1+2+3+4)	6 # Applicable Client Outcome Monitors (1+2+3+4)	7 % Outliers/ Applicable Outcome Monitors (5/6)
Outlier Direction								
1	Bedford	-39.2%				1	4	25%
1	Brockton					0	4	0%
1	Togus					0	4	0%
1	West Haven					0	4	0%
2	Albany					0	4	0%
2	Buffalo	-32.7%				1	4	25%
2	Canandaigua			4.1%		1	4	25%
2	Syracuse			4.4%		1	4	25%
3	Brooklyn					0	4	0%
3	Montrose					0	4	0%
3	New Jersey					0	4	0%
3	Northport			14.5%		1	4	25%
4	Coatesville					0	4	0%
4	Pittsburgh					0	4	0%
5	Martinsburg					0	3	0%
5	Perry Point					0	4	0%
6	Fayetteville					0	4	0%
6	Hampton					0	4	0%
6	Salem					0	4	0%
6	Salisbury			8.4%		1	4	25%
7	Atlanta					0	4	0%
7	Augusta					0	4	0%
7	Birmingham					0	4	0%
7	Tuscaloosa					0	4	0%
7	Tuskegee		5.4%			1	4	25%
8	Gainesville					0	4	0%
8	Miami					0	4	0%
8	Tampa					0	4	0%
10	Chillicothe					0	4	0%
10	Cincinnati	-41.2%				1	4	25%
10	Cleveland					0	4	0%
10	Columbus					0	4	0%
10	Dayton	-15.1%				1	4	25%
10	Youngstown					0	4	0%
11	Ann Arbor					0	4	0%
11	Battle Creek					0	4	0%
11	Detroit					0	4	0%
11	Northern Indiana					0	4	0%
12	Chicago-West Side					0	4	0%
12	Madison					0	4	0%
12	Milwaukee	-32.6%		16.2%		2	4	50%
12	North Chicago					0	4	0%
12	Tomah					0	4	0%
15	St. Louis					0	4	0%
15	Topeka					0	4	0%
16	Gulf Coast					0	4	0%
16	Houston					0	4	0%
16	Little Rock	-20.0%				1	4	25%
16	New Orleans	-22.8%				1	4	25%
17	Dallas					0	4	0%
17	Temple (Waco)					0	4	0%

VISN	SITE	1 365 Days % Change MH Days (Post-Pre) (Low)	2 Reported Symptoms % Change (BSI) (HIGH)	3 Observed Symptoms % Change (BPRS) (HIGH)	4 Quality of Life % Change (QOL) (LOW)	5 Total Client Outcome Outliers (1+2+3+4)	6 # Applicable Client Outcome Monitors (1+2+3+4)	7 % Outliers/ Applicable Outcome Monitors (5/6)
Outlier Direction								
18	Albuquerque					0	4	0%
18	Phoenix	-43.5%				1	4	25%
19	Denver					0	4	0%
19	Grand Junction	-43.4%				1	4	25%
19	Salt Lake City			4.9%		1	4	25%
19	Sheridan		25.1%	41.7%	-9.7%	3	4	75%
19	Southern Colorado					0	4	0%
20	American Lake			11.7%		1	4	25%
20	Boise					0	4	0%
20	Portland					0	4	0%
20	Seattle			19.1%		1	4	25%
21	Palo Alto					0	4	0%
21	San Francisco					0	4	0%
22	Greater Los Angeles					0	4	0%
22	San Diego					0	4	0%
23	Iowa City	-39.0%				1	4	25%
23	Knoxville					0	4	0%
23	Minneapolis			16.4%		1	4	25%
23	Omaha					0	4	0%
23	St. Cloud	-41.4%				1	4	25%
OUTLIER SITES (N)		11	2	10	1	21	283	7%
OUTLIER SITES (%)		15.5%	2.8%	14.1%	1.4%	33.8%	99.6%	33.9%
OUTLIER TOTAL						24	283	7%

[Client outcome monitors are presented in Report Tables 2-18a, 2-19, 2-20 and 2-23]

Note: There were two negative outliers for the IADL monitor. GAF and Satisfaction outcome monitors were excluded.

TABLE 2-32A. OUTLIERS FOR MINIMUM STANDARDS

VISN	SITE	1 % OF CLIENTS WITH PSYCHOTIC DX AT ENTRY	2 PERCENT OF CLIENTS WITH GTE 30 DAYS HOSP. PRIOR YR	3 # ADJUSTED FACE-FACE CONTACTS/WK/VETERAN	4 CASELOAD SIZE PER CLINICAL FTEE	5 % CLIENTS SEEN 60% OR MORE IN COMMUNITY	6 TEAM PROVIDES PSYCHIATRIC REHABILITAT'N SERVICES
Outlier Direction		(LT 50%)	(LT 50%)	(<1/WK)	7:1 TO 15:1	(<50%)	(<25%)
1	Bedford						
1	Brockton			0.87			
1	Togus						
1	West Haven						
2	Albany				15.4		
2	Buffalo		25.9	0.94			7.8
2	Canandaigua						
2	Syracuse			0.78		45.3	
3	Brooklyn			0.72			
3	Montrose						
3	New Jersey			0.96			
3	Northport						
4	Coatesville						
4	Pittsburgh			0.78	16.3		
5	Martinsburg			0.99			
5	Perry Point				15.1		
6	Fayetteville		48.0				21.7
6	Hampton						
6	Salem			0.92			23.3
6	Salisbury						
7	Atlanta						
7	Augusta				35.0		
7	Birmingham				6.3		
7	Tuscaloosa				15.8		
7	Tuskegee						
8	Gainesville				16.0		
8	Miami				21.2		
8	Tampa						
10	Chillicothe						
10	Cincinnati		47.6				
10	Cleveland						
10	Columbus			0.97			
10	Dayton		39.6				
10	Youngstown		45.2				
11	Ann Arbor						
11	Battle Creek				15.5		
11	Detroit			0.69			11.6
11	Northern Indiana						
12	Chicago-West Side						
12	Madison						
12	Milwaukee		30.0		6.3		
12	North Chicago						
12	Tomah						16.2
15	St. Louis				18.4		
15	Topeka						
16	Gulf Coast						
16	Houston		47.6	0.94			

VISN	SITE	1 % OF CLIENTS WITH PSYCHOTIC DX AT ENTRY	2 PERCENT OF CLIENTS WITH GTE 30 DAYS HOSP. PRIOR YR	3 # ADJUSTED FACE-FACE CONTACTS/WK/VETERAN	4 CASELOAD SIZE PER CLINICAL FTEE	5 % CLIENTS SEEN 60% OR MORE IN COMMUNITY	6 TEAM PROVIDES PSYCHIATRIC REHABILITAT'N SERVICES
Outlier Direction		(LT 50%)	(LT 50%)	(<1/WK)	7:1 TO 15:1	(<50%)	(<25%)
16	Little Rock						
16	New Orleans			0.83			
17	Dallas						
17	Temple (Waco)						
18	Albuquerque						
18	Phoenix			0.75			23.5
19	Denver						
19	Grand Junction						
19	Salt Lake City		42.6				
19	Sheridan			0.83			
19	Southern Colorado		22.3				
20	American Lake						
20	Boise		45.0	0.53			
20	Portland						
20	Seattle		42.9				20.0
21	Palo Alto			0.93			
21	San Francisco						
22	Greater Los Angeles			0.43			
22	San Diego				17.2		
23	Iowa City			0.97			
23	Knoxville						
23	Minneapolis			1.00			
23	Omaha						
23	St. Cloud			0.84			
OUTLIER SITES (N)		0	11	20	12	1	7
OUTLIER SITES (%)		0.0%	15.5%	28.2%	16.9%	1.4%	10%
OUTLIER TOTAL							

[Clinical process monitors are presented in Report Tables 2-12, 2-13, 2-14, and 2-15.]

Minimum Program Standards are identified in the MHICM Directive and derived from FY 2001 monitors.

Shaded "outlier" values fall beneath threshold levels for the minimum program standard.

TABLE 2-32B. OUTLIERS FOR MINIMUM STANDARDS

VISN	SITE	7 TENURE % CLIENTS DISCHARGED	8 TEAM SIZE # FULL-TIME CLINICAL STAFF	9 TOTAL MINIMUM PROGRAM STANDARDS OUTLIERS	10 % MINIMUM PROGRAM STANDARDS OUTLIERS	11 % MINIMUM PROGRAM STANDARDS OUTLIERS	12 CHANGE MINIMUM PROGRAM STANDARDS OUTLIERS
Outlier Direction		(>20%)	(4.0+FTEE)	(Col. 1..8)	(Col. 9/8)	FY 2001	FY04-FY01
1	Bedford			0	0.0%	12.5%	-12.5%
1	Brockton			1	12.5%	25.0%	-12.5%
1	Togus		2.70	1	12.5%	25.0%	-12.5%
1	West Haven			0	0.0%	0.0%	0.0%
2	Albany		3.25	2	25.0%	37.5%	-12.5%
2	Buffalo			3	37.5%	50.0%	-12.5%
2	Canandaigua			0	0.0%	0.0%	0.0%
2	Syracuse		3.00	3	37.5%	50.0%	-12.5%
3	Brooklyn	22.4%	3.90	3	37.5%	12.5%	25.0%
3	Montrose			0	0.0%	37.5%	-37.5%
3	New Jersey			1	12.5%	25.0%	-12.5%
3	Northport			0	0.0%		
4	Coatesville			0	0.0%	37.5%	-37.5%
4	Pittsburgh			2	25.0%	25.0%	0.0%
5	Martinsburg	30.3%	3.00	3	37.5%		
5	Perry Point	30.8%		2	25.0%	25.0%	0.0%
6	Fayetteville		3.40	3	37.5%		
6	Hampton	23.7%		1	12.5%		
6	Salem	27.3%	3.00	4	50.0%		
6	Salisbury	23.7%	2.50	2	25.0%	37.5%	-12.5%
7	Atlanta	27.9%		1	12.5%	25.0%	-12.5%
7	Augusta		2.00	2	25.0%	0.0%	25.0%
7	Birmingham		3.50	2	25.0%		
7	Tuscaloosa			1	12.5%		
7	Tuskegee			0	0.0%	50.0%	-50.0%
8	Gainesville		3.50	2	25.0%	12.5%	12.5%
8	Miami		2.50	2	25.0%		
8	Tampa		3.50	1	12.5%		
10	Chillicothe			0	0.0%	0.0%	0.0%
10	Cincinnati			1	12.5%	37.5%	-25.0%
10	Cleveland			0	0.0%	12.5%	-12.5%
10	Columbus		2.33	2	25.0%	37.5%	-12.5%
10	Dayton			1	12.5%	12.5%	0.0%
10	Youngstown		3.10	2	25.0%		
11	Ann Arbor		3.50	1	12.5%	12.5%	0.0%
11	Battle Creek			1	12.5%	0.0%	12.5%
11	Detroit			2	25.0%	12.5%	12.5%
11	Northern Indiana			0	0.0%		
12	Chicago-West Side			0	0.0%		
12	Madison		3.30	1	12.5%	12.5%	0.0%
12	Milwaukee	24.2%	3.50	4	50.0%		
12	North Chicago			0	0.0%	12.5%	-12.5%
12	Tomah		3.75	2	25.0%		
15	St. Louis	20.4%	2.50	3	37.5%		
15	Topeka			0	0.0%		
16	Gulf Coast	36.1%		1	12.5%		
16	Houston			2	25.0%	12.5%	12.5%

VISN	SITE	7 TENURE % CLIENTS DISCHARGED	8 TEAM SIZE # FULL-TIME CLINICAL STAFF	9 TOTAL MINIMUM PROGRAM STANDARDS OUTLIERS	10 % MINIMUM PROGRAM STANDARDS OUTLIERS	11 % MINIMUM PROGRAM STANDARDS OUTLIERS	12 CHANGE MINIMUM PROGRAM STANDARDS OUTLIERS
Outlier Direction		(>20%)	(4.0+FTEE	(Col. 1..8)	(Col. 9/8)	FY 2001	FY04-FY01
16	Little Rock			0	0.0%	12.5%	-12.5%
16	New Orleans		3.50	2	25.0%		
17	Dallas			0	0.0%	25.0%	-25.0%
17	Temple (Waco)	32.3%		1	12.5%		
18	Albuquerque			0	0.0%		
18	Phoenix	21.4%		3	37.5%		
19	Denver			0	0.0%	12.5%	-12.5%
19	Grand Junction	20.8%	3.50	2	25.0%	50.0%	-25.0%
19	Salt Lake City			1	12.5%	37.5%	-25.0%
19	Sheridan	22.2%	1.20	3	37.5%		
19	Southern Colorado			1	12.5%	50.0%	-37.5%
20	American Lake			0	0.0%	0.0%	0.0%
20	Boise		3.00	3	37.5%	12.5%	25.0%
20	Portland	23.1%		1	12.5%	0.0%	12.5%
20	Seattle		3.45	3	37.5%	12.5%	25.0%
21	Palo Alto	24.4%	3.00	3	37.5%		
21	San Francisco	22.9%	3.00	2	25.0%	25.0%	0.0%
22	Greater Los Angeles		3.50	2	25.0%	37.5%	-12.5%
22	San Diego		2.50	2	25.0%		
23	Iowa City			1	12.5%		
23	Knoxville	22.2%		1	12.5%	12.5%	0.0%
23	Minneapolis			1	12.5%	25.0%	-12.5%
23	Omaha		3.50	1	12.5%		
23	St. Cloud		3.10	2	25.0%		
OUTLIER SITES (N)		18	31	53	18%	22%	-7%
OUTLIER SITES (%)		25%	44%	75%			
OUTLIER TOTAL				100			

Table 2-33. SITE OUTLIER REVIEW SUMMARY

VISN	SITE	Site # of Outliers 2004 Total #	Reason A	Reason B	Reason C	Reason D	Reason E	Sum of Responses Reason A-E Total
			Legitimate differences not conflict with national goals # of A's	Local Policies may conflict with national goals # of B's	Implementation problems: Corrective action taken # of C's	Implementation problems: Corrective action planned # of D's	Implementation problems: No corrective action planned # of E's	
1	Bedford	1	1	0	0	0	0	1
1	Brockton	1	0	0	1	0	0	1
1	Togus	1	0	0	1	0	0	1
1	West Haven	1	0	1	0	0	0	1
2	Albany	3	0	0	1	2	0	3
2	Buffalo	4	2	0	2	0	0	4
2	Canandaigua	2	1	0	0	1	0	2
2	Syracuse	5	0	0	4	0	1	5
3	Brooklyn	5	2	0	1	1	0	4
3	Montrose	2	0	1	0	0	0	1
3	New Jersey	1	0	1	0	0	0	1
3	Northport	2	1	0	0	1	0	2
4	Coatesville	1	0	0	1	0	0	1
4	Pittsburgh	3	3	0	0	0	0	3
5	Martinsburg	5	0	0	0	0	0	0
5	Perry Point	4	1	0	3	0	0	4
6	Fayetteville	4	1	0	1	2	0	4
6	Hampton	1	0	0	1	0	0	1
6	Salem	5	0	0	5	0	0	5
6	Salisbury	4	3	0	1	0	0	4
7	Atlanta	2	0	0	2	0	0	2
7	Augusta	4	0	0	4	0	0	4
7	Birmingham	2	2	0	0	0	0	2
7	Tuscaloosa	2	0	0	1	0	0	1
7	Tuskegee	3	0	0	1	1	1	3
8	Gainesville	2	0	0	2	0	0	2
8	Miami	3	0	0	3	0	0	3
8	Tampa	3	1	0	1	1	0	3
10	Chillicothe	0	0	0	0	0	0	0
10	Cincinnati	3	2	1	0	0	0	3
10	Cleveland	0	0	0	0	0	0	0
10	Columbus	5	1	0	3	0	1	5
10	Dayton	4	0	2	1	0	0	3
10	Youngstown	4	2	0	1	1	0	4
11	Ann Arbor	1	0	0	0	1	0	1
11	Battle Creek	3	0	0	3	0	0	3
11	Detroit	3	0	1	0	2	0	3
11	Northern Indiana	1	0	0	1	0	0	1
12	Chicago-West Side	0	0	0	0	0	0	0
12	Madison	1	0	1	0	0	0	1
12	Milwaukee	6	0	0	0	0	0	0
12	North Chicago	1	1	0	0	0	0	1
12	Tomah	2	0	0	0	1	1	2
15	St. Louis	5	2	1	2	0	0	5
15	Topeka	0	0	0	0	0	0	0
16	Gulf Coast	1	0	0	0	0	0	0
16	Houston	2	1	0	1	0	0	2
16	Little Rock	1	0	1	0	0	0	1
16	New Orleans	3	1	0	1	1	0	3
17	Dallas	2	1	0	1	0	0	2
17	Temple (Waco)	2	2	0	0	0	0	2
18	Albuquerque	1	0	1	0	0	0	1
18	Phoenix	5	1	2	2	0	0	5
19	Denver	1	1	0	0	0	0	1
19	Grand Junction	4	2	2	0	0	0	4
19	Salt Lake City	2	0	0	0	2	0	2
19	Sheridan	6	0	0	0	0	0	0
19	Southern Colorado	2	0	1	0	0	0	1
20	American Lake	1	0	0	1	0	0	1
20	Boise	3	3	0	0	0	0	3
20	Portland	1	0	0	0	1	0	1
20	Seattle	5	0	1	0	0	4	5
21	Palo Alto	4	0	0	4	0	0	4

Table 2-33. SITE OUTLIER REVIEW SUMMARY

VISN	SITE	Site # of Outliers 2004 Total #	Reason A	Reason B	Reason C	Reason D	Reason E	Sum of Responses Reason A-E Total
			Legitimate differences not conflict with national goals # of A's	Local Policies may conflict with national goals # of B's	Implementation problems: Corrective action taken # of C's	Implementation problems: Corrective action planned # of D's	Implementation problems: No corrective action planned # of E's	
21	San Francisco	3	0	1	0	0	0	1
22	Greater Los Angeles	3	1	0	2	0	0	3
22	San Diego	3	0	0	3	0	0	3
23	Iowa City	3	0	1	0	2	0	3
23	Knoxville	3	1	0	1	1	0	3
23	Minneapolis	2	1	0	1	0	0	2
23	Omaha	3	3	0	0	0	0	3
23	St. Cloud	3	0	0	1	2	0	3
OUTLIER SITES (N)		71	28	16	36	17	5	63
OUTLIER SITES (%)		100.0%	39.4%	22.5%	50.7%	23.9%	7.0%	100.0%
OUTLIER RESPONSES (N)		184	44	19	65	23	8	159
OUTLIER RESPONSES (%)		100%	23.9%	10.3%	35.3%	12.5%	4.3%	86.4%

Source: MHICM Outlier Review, FY 2004

+ No Outliers

Figure 2-1. Travel Distance from MHICM offices to veteran residence.
Percent of veterans with case manager reported follow-up data N=3,548).

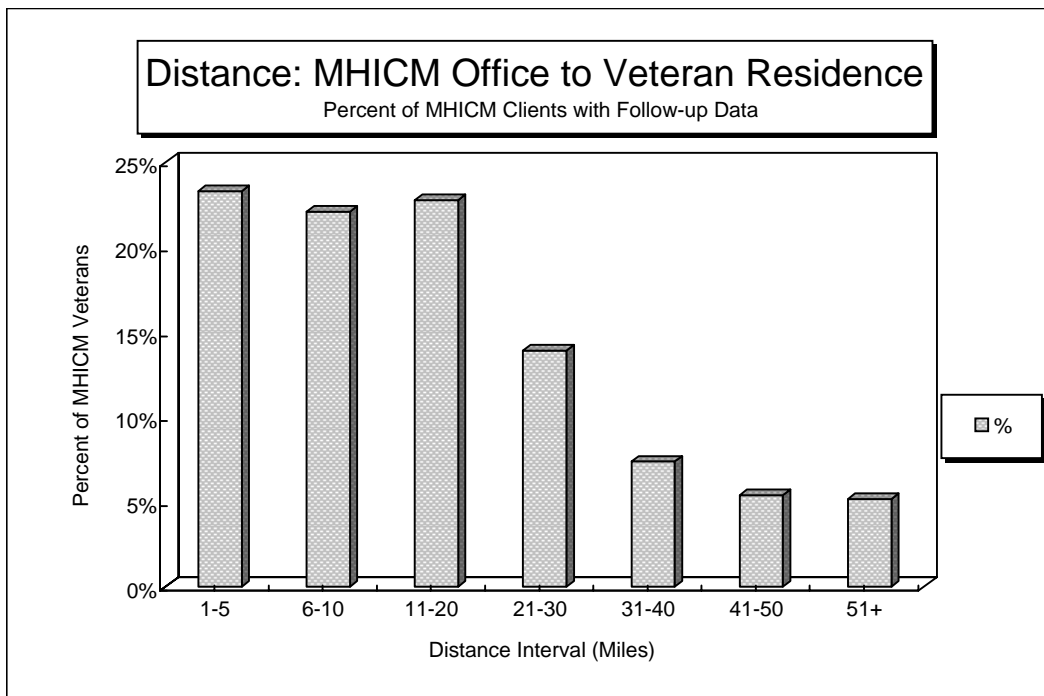


Figure 2-2. Travel Time from MHICM offices to veteran residence.
Percent of veterans with case manager reported follow-up data (N=3,512).

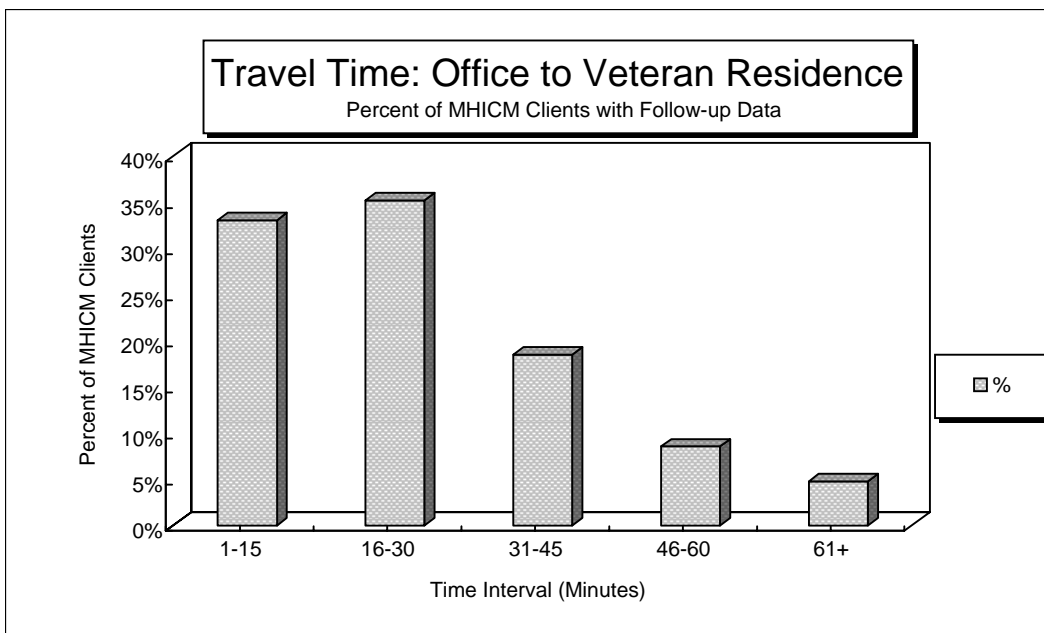


Figure 2-3. MHICM clients reporting expression of violence or criminal justice involvement.
Percent at entry (N=4,010) vs. Follow-up (N=2,752).

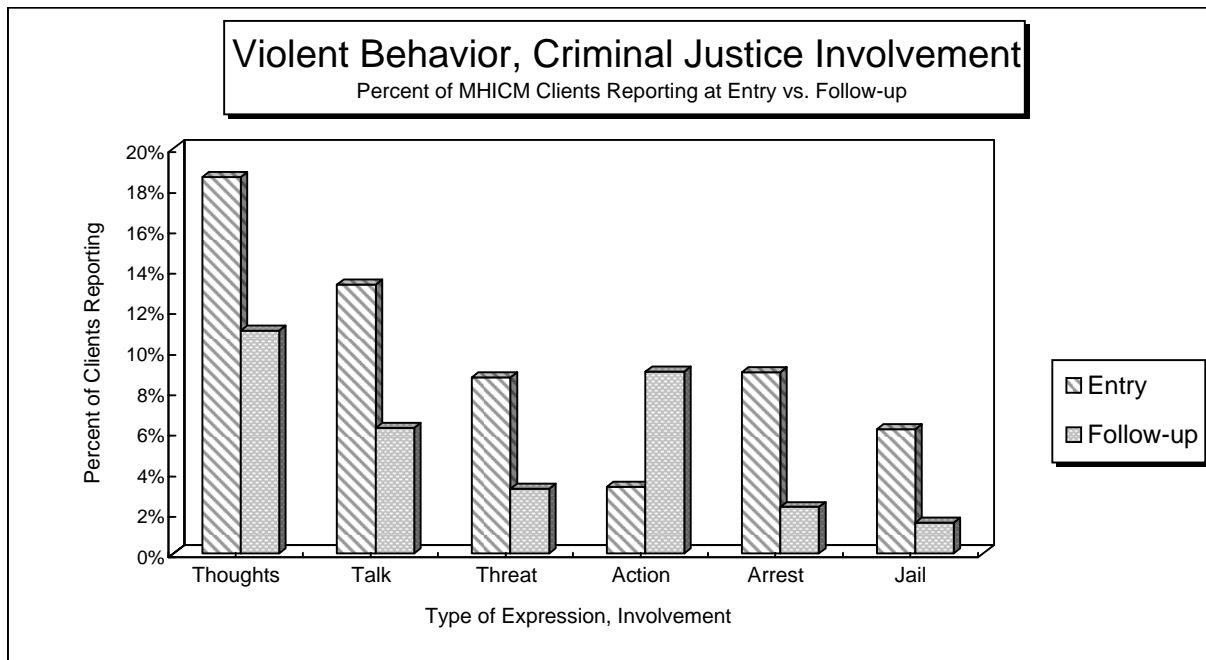


Figure 2-4. MHICM clients reporting expression of suicidality, hospitalization.
Percent at entry (N=3,957) vs. Follow-up (N=2,692).

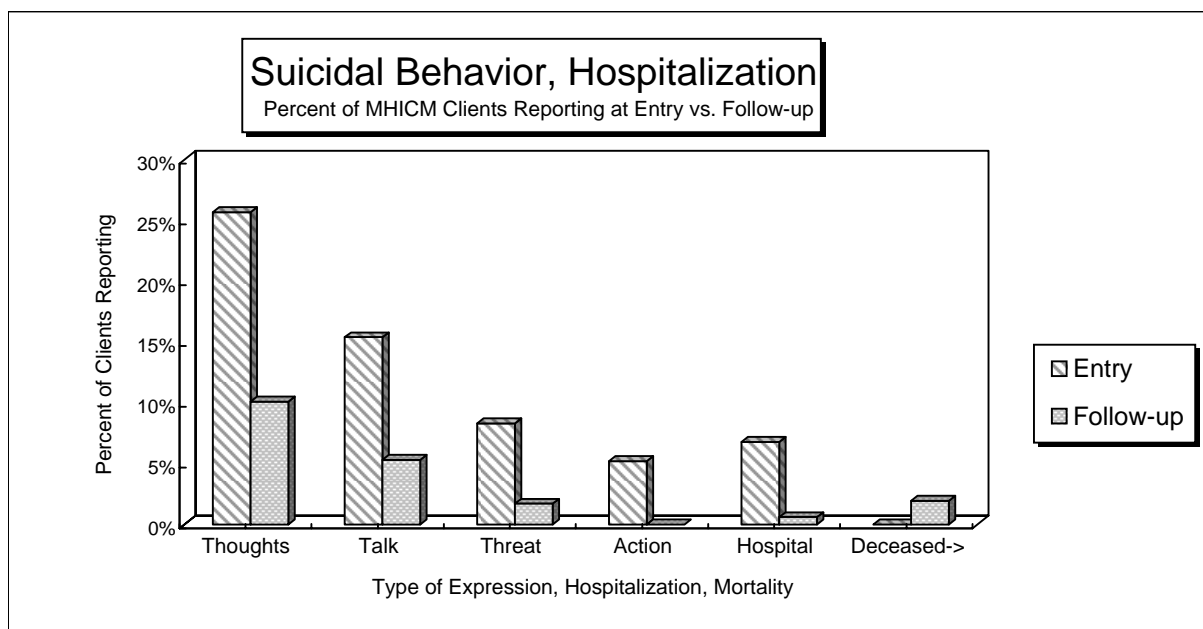


Figure 2-5. MHICM clients reporting living arrangements by level of independence.
Percent at entry (N=4,000) vs. follow-up (N=2,764).

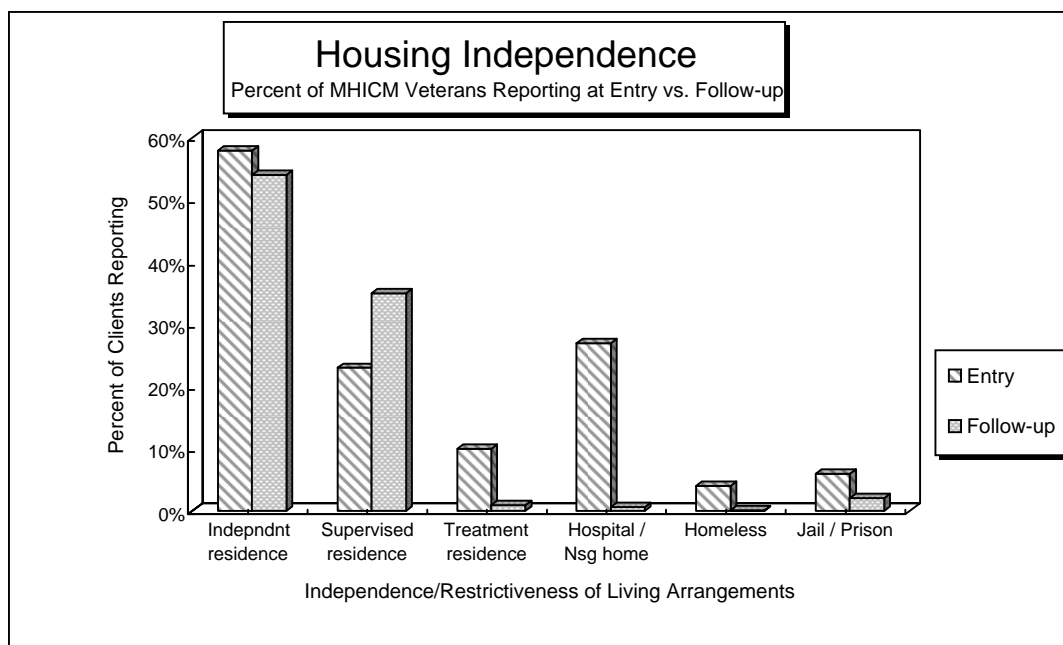
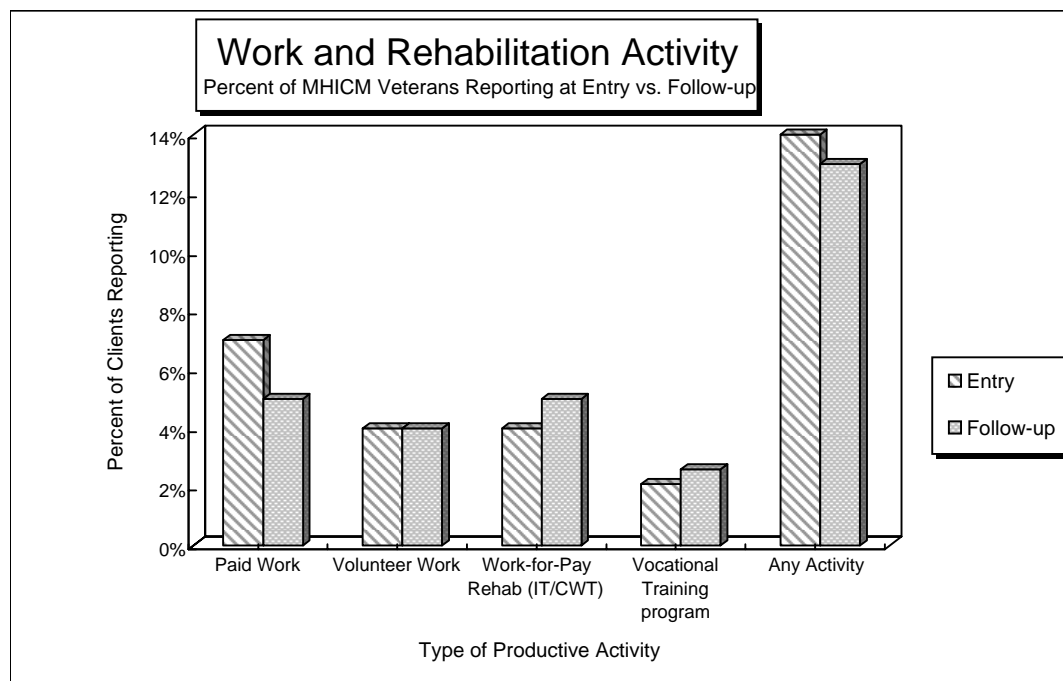


Figure 2-6. MHICM clients reporting participation in productive activity.
Percent at entry (N=4,057) vs. follow-up (N=2,805).



Appendices

- Appendix A. VHA Directive 2000-034 (“MHICM Directive”)
- Appendix B. MHICM Planning Material & Checklists
- Appendix C. Outlier Review Request and Form
- Appendix D. Legend for MHICM Performance Report Tables
- Appendix E. MHICM Case Management Services, FY 2004 (Registered Veterans)
- Appendix F. Non-MHICM Case Management Services, FY 2004
- Appendix G. MHICM Complex VERA Veterans, FY 2004
- Appendix H. MHICM Program Monitor Trends, FY 1997 – 2004.

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Appendix A

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA DIRECTIVE 2000-034
October 2, 2000

VHA MENTAL HEALTH INTENSIVE CASE MANAGEMENT (MHICM)

1. PURPOSE: This Veterans Health Administration (VHA) Directive describes a new initiative in mental health intensive case management (MHICM) for seriously mentally ill veterans. **NOTE:** *This initiative takes the place of existing Intensive Psychiatric Community Care (IPCC) programs, Intensive Community Case Management (ICCM) programs, as well as other similar assertive community treatment (ACT) programs within VHA.*

2. BACKGROUND

a. Severe mental illness, primarily psychoses, is a major problem among veterans. Fiscal Year (FY) 1998 Compensation and Pension (C&P) data indicate that 136,362 veterans are service-connected for psychoses of which over 67,700 use VHA services. Over 174,030 veterans with psychoses, overall, used VHA services in FY 1998. The clinical literature suggests that approximately 20 percent of severely mentally ill patients are in need of intensive community case management services in the typical public mental health system. This intensive multidisciplinary team approach to ambulatory management and treatment of patients in, and coordinated with the community and its services, is clearly distinguished from usual case management by: engagement in community settings of highly dysfunctional patients traditionally managed in hospitals; an unusually high staff to patient ratio; multiple visits per week if needed; interventions primarily in the community rather than in office settings; and fixed team responsibility, around the clock, for total patient care over a prolonged period (see subpar. 2e(2)). Multiple studies, including three recent VHA studies, have shown that the intervention is cost effective, particularly where the service is offered to chronically ill, hospitalized patients and where the model is rigorously adhered to with respect to assertiveness of the intervention and maintaining low caseloads (see sub par. 2d). There is compelling evidence for the effectiveness of ACT in patients with psychosis, but its use may also be considered in severe and persistent affective disorder, post-traumatic stress disorder (PTSD), etc., where independent functioning is impaired. A FY 1998 survey by the Committee on Care of Severely Chronically Mentally Ill (SCMI) Veterans revealed that just over 8,000 veterans currently received some form of mental health team case management from VHA, and of those, only 2,000 met ACT Fidelity Measures criteria for intensive case management. Therefore, a gap in these state-of-the-art services is evident, resulting in unnecessary costs and patient morbidity to VHA.

b. On March 25, 1999, in order to obtain a wider range of views in formulating a VHA-wide approach, the Chief Network Officer appointed a SCMI Strategic Implementation Committee composed of four Clinical Managers, a medical center Director, a Mental Health Care Line Director, the National Director of the Northeast Program Evaluation Center (NEPEC), a representative of Vietnam Veterans Association, and a representative of the Mental Health Strategic Healthcare Group.

THIS VHA DIRECTIVE EXPIRES OCTOBER 31, 2005

c. The SCMI Strategic Implementation Committee considered various models of intensive case management within the Mental Health service area, then defined intensive case management for the severely mentally ill in VHA and the accountability expected from this designated program.

d. MHICM is a cost effective intervention given appropriate case selection. This may seem like a paradox given the known resource intensity of the interventions. The efficiency (offset) results from avoidance of other costly interventions such as multiple or lengthy hospitalizations, and extensive ambulatory clinic use, including visits to emergency rooms. Paragraph 3 notes that these programs need to be established from existing funds. To realize the efficiency and accomplish this out of existent resources requires a shift of resources that previously supported the extensive inpatient and outpatient use to underwrite MHICM. It is acknowledged that there will be a need for expedited mental health resource shifts, as well as shifts from other programs that gain economies from implementation of MHICM, including bed closures, where justified, as this more effective alternative of MHICM is implemented.

e. **Definitions**

(1) **Target Population.** MHICM programs are intended to provide necessary treatment and support for veterans who meet all of the following five criteria:

(a) Diagnosis of Severe and Persistent Mental Illness. Diagnosis of severe and persistent mental illness includes, but is not limited to: schizophrenia, bipolar disorder, major affective disorder, or severe post-traumatic stress disorder;

(b) Severe Functional Impairment. Severe functional impairment is such that the veteran is neither currently capable of successful and stable self-maintenance in a community living situation nor able to participate in necessary treatments without intensive support;

(c) Inadequately Served. This means inadequately served by conventional clinic-based outpatient treatment or day treatment;

(d) High Hospital Use. High hospital use as evidenced by over 30 days of psychiatric hospital care during the previous year or three or more episodes of psychiatric hospitalization;

(e) Clinically Appropriate for MHICM Approach. Patients who are more appropriately managed clinically as inpatients need to remain in the inpatient setting; that is, the positive aspects of MHICM should not be used to justify moving patients who would be better served by inpatient care to this ambulatory care model.

(2) **Description of the Program.** MHICM programs are delivered by an integrated, multidisciplinary team and are based on the Substance Abuse Mental Health Services Administration (SAMHSA) ACT standards. There are four core treatment elements:

(a) Very Frequent Contacts between Care Givers and Patients. The treatment process would include two phases:

1. High intensity of care primarily through home and community visits, with low caseloads (seven to fifteen veterans per clinician), allowing rapid attention to crisis and development of community living skills to prevent crisis in this exceptionally vulnerable population.

2. Appropriate transition to lower intensity care. After 1 year of MHICM treatment, patients can be transferred to either standard care or to continuous treatment by the MHICM team at a lower level of intensity (e.g., with caseloads of up to 30 per clinician). Characteristics of the readiness for a lower level of care would include the following: patients are clinically stable, not abusing addictive substances, not relying on extensive inpatient or emergency services, capable of maintaining themselves in a community living situation, and independently participating in necessary treatments.

NOTE: NEPEC will monitor this transition through periodic clinical progress reports and will report both levels of intensity separately.

(b) Flexibility and Community Orientation. Flexibility and community orientation with most services provided in community settings and involving integration with natural support systems whenever possible (e.g., family members, landlords, employer).

(c) Focus on Rehabilitation. Focus on rehabilitation through practical problem solving, crisis resolution, adaptive skill building, and transition to self-care and independent living where possible.

(d) Responsibility. Identification of the team as a "fixed point of clinical responsibility" providing continuity of care for each veteran, wherever the veteran happens to be, for a prolonged period. This is expected to initially be 1 year, but subsequently will be based on a periodic review of continuing need for intensive services.

(3) Data Recording

(a) Attachment A-A. Attachment A-A contains the definitions of the revised Decision Support System (DSS) Identifiers for the MHICM workload (546 and 552) as well as the new code for general (non-intensive) mental health case management (564).

(b) Attachment A-B. Attachment A-B provides Veterans Integrated Service Networks (VISNs) and Department of Veterans Affairs (VA) leadership with population-based data to help facilitate assessment of the need for MHICM teams in each VISN. These data include the number of:

1. Veterans who meet inpatient utilization criteria (30 days of psychiatric hospitalization or three admissions);
2. Outpatients who meet diagnostic criteria for schizophrenia, bipolar, or major affective disorder and had six or more mental health outpatient contacts in FY 1998;
3. Veterans in the Psychiatric Special Care category under the Veterans Equitable Resource Allocation (VERA) system, and
4. Psychiatric patients with lengths of stay over 1 year.

(c) After a period during which new teams will be added to the roster of MHICM teams participating in the national program, NEPEC will present a data summary for each VISN of the ratio of MHICM-treated patients to those potentially eligible as estimated by each of the indicators of population need identified in Appendix B. VISNs may use these data to identify potential service gaps.

3. POLICY: It is VHA policy to support the development of case management approaches sufficient to meet the need where appropriate. Where the need for intensive mental health case management is demonstrated, MHICM programs need to be established out of existing funds (see subpar. 2d). ***NOTE:** NEPEC, which has developed and evaluated this type of program for 10 years, is providing the leadership for training and monitoring of new and established teams.*

4. ACTION

a. Facility Actions. Facilities are to:

- (1) Utilize national DSS identifiers to designate MHICM activity.
- (2) Provide complete nationally-adopted monitoring information for MHICM in a timely manner.

(3) Maintain team fidelity to the operating principles as described in the program description (see subpar. 2e(2)) and adhere to evidence-based clinical procedures. Adequate resources are needed to provide a critical mass of staff to comprehensively address the needs of these exceptionally vulnerable patients, even in the face of staff turnover and other absences. **NOTE:** *At least four clinical Full-time Employee Equivalent (FTEE) are needed for each MHICM team. Additional team members may be required in circumstances where the team is isolated from a VA medical center that can provide 24-hour coverage and emergency services. At sites where there are insufficient patients to justify a full team, consideration is to be given to partnering with the community, e.g., existing ACT teams.*

b. **Monitoring and Training Actions.** Because MHICM is resource intensive and the participating veterans are vulnerable, the following monitoring procedures will be implemented under the leadership of NEPEC. **NOTE:** *Forms may be obtained by contacting NEPEC by e-mail at "Robert.Rosenheck@med.VA.gov" or telephone at (203) 937-3850.*

(1) **Standard Intake Data Form (IDF).** Standard IDF will be administered to all new admissions to MHICM. It will document adherence to the eligibility criteria listed above and record baseline data on clinical status, functional impairment, and satisfaction with services. The IDF takes about 30 to 45 minutes to complete per patient.

(2) **Follow-up Data Form (FDF).** Follow-up FDF must be administered 6 months and 1 year after program entry and annually thereafter. It consists of a subset of health status and community adjustment measures from IDF. The FDF takes about 25 to 30 minutes to complete per patient.

(3) **A Clinical Process Form (CPF).** A CPF will document delivery of MHICM service elements and will be completed by each client's primary case manager every 6 months after program entry. The CPF takes about 15 minutes to complete on each patient.

(4) **MHICM Check List and ACT Fidelity Measure.** The MHICM Check List and ACT Fidelity Measure is to be completed by the program director once a year for the entire program. This form takes about 20 minutes to complete.

(5) **VHA Administrative Data.** VHA administrative data will be used to track MHICM process and outcomes using inpatient and outpatient service utilization data available from the Patient Treatment File and the Outpatient Care File in the Austin Data Processing Center.

c. **Mental Health Strategic Healthcare Group (MHSHG) Actions.** The MSHSG will:

(1) Assess, deploy, evaluate, and disseminate quality and cost efficient best practices by utilizing NEPEC, Management Science, and Allocation Resource Center data and expertise.

(2) Oversee effectiveness of MHICM program, monitoring, training, and evaluation by convening a broad based panel of experts to assess clinical and deployment outcomes and to determine future actions.

(a) The expert panel will consist of a NEPEC-based Chair (non-voting), five field members including a Chief Financial Officer (CFO), and three NEPEC and/or VHA Headquarters members. The panel will meet as needed but at least quarterly.

(b) The expert panel will provide a regular biannual summary report of its findings, conclusions and recommendations to the Policy Board.

(c) The expert panel will be responsible for preparing an annual cost and benefit analysis for the Policy Board.

(d) The expert panel will oversee, account, and provide a progress report to the Policy Board at appropriate times, but no less than annually, on the shift of resources to offset the resource needs of the MHICM program.

d. **NEPEC Actions.** NEPEC will:

(1) Provide direct oversight to all MHICM programs to ensure that standards are met through periodic site visits to treatment teams, regular national meetings of team leaders, conference calls, consultation, and national training programs. Programs systematically not meeting standards may be decertified from using the MHICM DSS Identifiers.

(2) Make additional efforts to integrate this data collection into standard VA computerized data systems, to provide sites with spreadsheet summaries of national and site-by-site program results on a regular basis, and to provide clinicians with client-specific output for clinical review.

(3) Be responsible for:

(a) Producing periodic reports on the structure, process, and outcomes of MHICM services for training programs in evaluation and clinical procedures.

(b) Working with the expert panel and its CFO (see subpar. 4c(2)) in the development of an effective costing system, such as activity-based costing, to account the MHICM program.

(c) Facilitating ongoing communication and linkage among programs across the country.

(d) Generating reports on VISN-level population-based needs assessments.

(e) Informing VISN and VA facility-level leadership where standards are problematic and recommending actions to strengthen the MHICM teams.

e. **Network Action.** Each Network will be responsible for:

(1) Addressing population-based needs for MHICM services;

(2) Establishing strategies to provide their severely mentally ill veterans within the described target population (see subpar. 2e(1)) access to MHICM services sufficient to meet the need, and

(3) Supporting recommendations by NEPEC to maintain MHICM standards.

5. REFERENCES: VHA Program Guide 1103.3, June 3, 1999, pages 9-11, 47. **NOTE:** See <http://vawww.mentalhealth.med.va.gov/MHICMRef.htm> on VHA intranet for current clinical references.

6. FOLLOW-UP RESPONSIBILITY: The Chief Consultant, Mental Health Strategic Healthcare Group (116) is responsible for the contents of this Directive.

7. RESCISIONS. None. This VHA Directive expires the last working day of September 2005.

Thomas L. Garthwaite, M.D.
Under Secretary for Health

Attachments

DISTRIBUTION: CO: E-mailed 10/05/00
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ATTACHMENT A-A: DSS IDENTIFIERS (STOPCODE) FOR FISCAL YEAR 2003

(Abstracted from VHA Directive 2003-090) (Note these are updated from the original Directive appendix)

Name/ Description	Stop code	CDR Account	Effective Date	Definition
TELEPHONE/MHICM	546	2780.00	10/1/99	Records patient consultation or psychiatric care, management, advice, and/or referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical, professional staff assigned to the special MHICM teams (see DSS Identifier 552). Includes administrative and clinical services. **Provisions of 38 U.S.C. Section 7332 require that records which reveal the identity, prognosis, diagnosis, or treatment of VA patients which relate to drug abuse, alcoholism or alcohol abuse, infection with HIV, or sickle cell anemia, are strictly confidential and may not be released or discussed unless there is written consent from the individual.
MENTAL HEALTH INTENSIVE CASE MANAGEMENT (MHICM)	552	5117.00	10/1/99	<u>Only VA medical centers approved to participate in MHICM (previously IPCC) programs monitored by NEPEC may use this code.</u> This records visits with patients and/or their families or caregivers by MHICM staff at all locations including VA outpatient or MHICM satellite clinics, MHICM storefronts, MHICM offices, or home visits. Includes clinical and administrative services provided to MHICM patients by MHICM staff. Additional stop codes may not be taken for the same workload.
GENERAL TEAM CASE MANAGEMENT	564	2311.00	10/1/99	Records visits with patients and/or their families or caregivers by members of a case management team performing mental health community case management at all locations. Includes administrative and clinical services provided to patients by team members. <u>NOT</u> to be used for visits by MHICM teams (see DSS Identifier 552) or for case management by individuals who use other stop codes.
MENTAL HEALTH INTENSIVE CASE MANAGEMENT (MHICM) GROUP	567	2314.00	10/1/02	<u>Only VA medical centers approved to participate in MHICM (previously IPCC) programs monitored by NEPEC may use this code.</u> This records group visits with patients and/or their families or caregivers by MHICM staff at all locations including VA outpatient or MHICM satellite clinics, MHICM storefronts, MHICM offices, or home visits. Includes clinical and administrative services provided to MHICM patients by MHICM staff. Additional stop codes may not be taken for the same workload.

ATTACHMENT A-B: MHICM TREATMENT POPULATION ESTIMATE FOR PLANNING PURPOSES

Note: This is the original table from the Directive appendix

VISN	Population Statistics			Discharged Psychiatric Inpatients (1)			Seriously Mentally Ill MH Outpatients			Psychiatric Complex VERA Class Patients (CMI)				Long-Term Inpatients (>1 yr LOS)		
				Total Psychiatric Inpatients (1)	Percent Inpatients Eligible for MHICM (2)	Number Inpatients Eligible for MHICM (2)	Total SMI Out-patients (3)	Percent Out Pt's with 6 OP MH Visits (4)	Number Out Pt's with 6 OP MH Visits (4)	Schizophrenia and Dementia	Other Psycho-sis	PTSD	Total	<u>Bed Sections</u> Med/ Psych. Surg Total		
	Total Veterans	Eligible for VA Services	SC for MH Problem		Psych.	Surg		Total								
1	1,500,892	358,094	32,435	5,204	30.9%	1,606	14,489	56.7%	8,220	926	324	435	1,685	94	20	114
2	697,421	194,415	12,296	2,355	41.8%	985	6,699	59.1%	3,961	440	171	200	811	18	0	18
3	1,595,593	335,211	29,644	4,716	45.9%	2,166	13,823	60.4%	8,348	1,250	377	505	2,132	196	23	219
4	1,819,870	497,402	27,526	5,047	35.7%	1,801	14,315	53.5%	7,660	930	295	465	1,690	51	9	60
5	857,564	168,218	9,715	3,405	29.3%	998	7,521	57.3%	4,310	502	112	365	979	62	13	75
6	1,251,189	360,885	22,017	4,936	30.1%	1,487	8,955	44.9%	4,023	501	149	319	969	64	1	65
7	1,367,528	399,439	25,458	4,888	29.1%	1,422	13,664	51.0%	6,967	790	175	569	1,534	67	43	110
8	1,634,357	482,839	43,852	5,083	18.3%	931	22,052	43.8%	9,658	440	247	506	1,193	0	0	0
9	1,060,416	367,654	21,666	4,246	21.9%	931	10,626	42.2%	4,481	391	136	169	696	65	0	65
10	1,151,473	318,983	16,861	3,993	32.9%	1,314	9,416	60.4%	5,691	720	196	372	1,288	4	0	4
11	1,651,186	427,356	18,906	4,240	24.2%	1,025	10,279	44.1%	4,528	849	188	284	1,321	193	25	218
12	1,362,314	319,235	15,530	4,372	39.8%	1,739	10,012	57.7%	5,773	606	368	410	1,384	70	0	70
13	707,005	210,110	11,153	2,533	40.9%	1,036	6,890	63.1%	4,346	317	173	190	680	1	0	1
14	516,075	153,798	6,675	1,711	41.2%	705	3,826	45.3%	1,732	194	102	140	436	0	0	0
15	1,071,604	329,293	15,963	4,152	27.3%	1,132	11,016	47.5%	5,229	540	277	342	1,159	7	0	7
16	1,887,301	651,983	39,737	6,995	30.9%	2,163	17,424	45.1%	7,865	877	256	534	1,667	1	0	1
17	1,026,699	321,378	17,795	3,727	37.4%	1,394	9,412	43.0%	4,046	669	314	404	1,387	169	1	170
18	842,132	276,151	15,687	2,833	18.0%	511	9,182	53.9%	4,945	152	118	274	544	0	0	0
19	731,842	215,445	11,835	2,490	34.1%	850	8,137	59.9%	4,876	317	195	337	849	0	0	0
20	1,191,422	342,926	21,245	4,444	32.7%	1,452	10,381	54.9%	5,702	301	227	416	944	0	0	0
21	1,418,772	338,504	19,259	3,292	38.2%	1,257	11,108	60.2%	6,689	518	263	524	1,305	0	0	0
22	1,841,007	418,847	20,114	3,627	29.5%	1,069	17,070	55.5%	9,478	713	463	364	1,540	1	0	1
TOTAL	27,183,662	7,488,166	455,369	88,289	31.7%	27,974	246,297	52.18%	128,528	12,943	5,126	8124	26,193	1,063	135	1,198
AVG	1,235,621	340,371	20,699	4,013	32.3%	1,272	11,195	52.70%	5,842	588	233	369	1,191	48	6	54
STD	397,725	113,743	9,168	1,171	7.4%	425	4,042	6.80%	1,982	268	93	121	420	63	11	70
CV	0.32	0.33	0.44	0.29	0.23	0.33	0.36	12.90%	0.34	0.46	0.40	0.33	0.35	1.30	1.85	1.28

(1) Discharged from Psychiatric bed sections, or other acute bed sections, or Domiciliary care with psychiatric primary diagnosis (excluding addictive disorders).

(2) Either greater than 30 bed days of care per year OR 3 or more admissions.

(3) Diagnosis of schizophrenia, major affective disorder, or bipolar disorder (ICD-9 codes 295.00-296.99).

(4) The official definition of an SMI patient in VA's capacity monitoring requires 6 or more OP visits per year.

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Appendix B

MHICM Planning Material and Checklists

July 26, 2005

Director, NEPEC / VA MHICM/IPCC Project Director

MHICM Planning Guidelines

Facility or VISN Representative

1. Thank you for your interest in VA Mental Health Intensive Case Management (MHICM) programs (formerly known as Intensive Psychiatric Community Care or IPCC). In response to many inquiries about MHICM teams, we have assembled this package of materials and guidelines to help VA facility and network level planners evaluate the benefits of implementing an MHICM team. It includes:

A. Descriptive materials: 1) summary of the program's history and scientific foundation; 2) summary of the program's mission, objectives, and monitoring domains; 3) brief bibliography; 4) list of current MHICM teams.

B. Standards and Implementation Checklist: 1) outline of minimum standards and expectations for starting an MHICM team; 2) MHICM implementation checklist.

C. Report and literature: 1) FY 2004 NEPEC MHICM report; 2) 1998 IPCC outcomes paper.

2. Would you like to learn more about Mental Health Intensive Case Management (MHICM)?

To learn more about the history, principles, and outcomes of MHICM, review the descriptive materials and literature and VHA Directive 2000-034, "Mental Health Intensive Case Management", available at <http://vaww.va.gov/publ/direc/health/direct/12000034.htm> and Appendix A of the MHICM Annual Report.

3. Are you interested in starting an MHICM team at your facility or in your VISN?

To learn more about key elements of an MHICM team, review the enclosed minimum standards and the MHICM implementation checklist.

4. Have you considered reconfiguring an existing staff unit into an MHICM team?

How closely do your community services resemble MHICM?

To compare a planned or existing program with MHICM services, review the enclosed minimum standards and complete the enclosed MHICM implementation checklist. Scoring your planned or existing community services team with the checklist will help us know how best to work with you.

**5. Could an MHICM team improve mental health services at your facility?
Could NEPEC training and monitoring enhance the effectiveness or efficiency of an
existing team?**

NEPEC publishes an annual report on MHICM teams with extensive information on program operation, as well as scientific papers in peer-reviewed journals. To learn more about NEPEC monitoring of MHICM teams, look at Chapter 2 in the FY 2004 report for tables on MHICM client characteristics, program structure, service delivery, clinical outcomes, and costs. Appendix A includes VHA Directive 2000-034, which defines MHICM services and monitoring. Appendix D provides a legend for each table. To learn more about MHICM outcomes, review the clinical and cost data from the Archives of General Psychiatry paper on the original IPCC experimental evaluation.

**6. Would you like NEPEC's assistance with starting or reconfiguring a team, training staff, or
monitoring outcomes at your facility?**

To request consultation and training to establish an MHICM team, to reconfigure an existing program to MHICM, or to include an existing community treatment team in NEPEC national monitoring, please send a completed copy of the enclosed MHICM Implementation checklist to:

Robert Rosenheck MD
Northeast Program Evaluation Center (NEPEC)/182
VA Connecticut Healthcare System
950 Campbell Avenue, West Haven, CT 06516
203-937-3850.

7. Thanks again for your interest in MHICM services for veterans with serious mental illness.
We hope the enclosed materials are helpful to you.

Robert Rosenheck, M.D.
Director, NEPEC

Michael Neale, Ph.D.
VA MHICM Project Director

What is MHICM?

VHA Mental Health Intensive Case Management (MHICM) teams provide community-based psychiatric and rehabilitation services to veterans with serious mental illness who are among the most frequent and long-term users of VA inpatient mental health resources. MHICM services are characterized by high staff -client ratios, shared caseloads, assertive outreach, frequent contact in community settings, a practical problem-solving approach, and high continuity of care. Interdisciplinary teams assume primary care responsibility and provide individualized care to help veterans: 1) reduce inpatient mental health service use and cost; 2) improve community adjustment and quality of life; and 3) enhance satisfaction with services. All MHICM veterans and staff participate in standardized national monitoring of program resources, client characteristics, service delivery, and outcomes in collaboration with the Northeast Program Evaluation Center (NEPEC). Evaluation and monitoring data have demonstrated the clinical and cost effectiveness of MHICM.

MHICM services are based on principles and standards of assertive community treatment (ACT), which has been identified as an evidence-based practice for people with serious mental illnesses. VHA Directive 2000-034 defines MHICM services and monitoring within VA. Cost effectiveness studies have shown that MHICM can be effective and efficient in the VA system. MHICM staffing standards (at least 3-4 FTEE) represent a minimum relative to published ACT standards (i.e., 8-15 FTEE). A MHICM team should have sufficient staff to provide the comprehensive, intensive community-based services the standards suggest. Because MHICM teams are less richly staffed than standard ACT teams, there are occasions when clients must be referred for day treatment, medical, substance abuse, or vocational services. On the other hand, location of MHICM teams within integrated VA mental health service systems allows most veterans to receive a range of services with continuous team support and minimal fragmentation.

The ninety teams currently providing MHICM services to 4,700 veterans in 41 states nationwide are listed on the next page.

Robert Rosenheck MD

Director, NEPEC

Michael Neale PhD

Associate Director, NEPEC

MHICM Project Director

Northeast Program Evaluation Center (NEPEC)/182

VA Connecticut Healthcare System

950 Campbell Avenue, West Haven, CT 06516

203-937-3850.

VA Intranet: <http://vaww.nepec.mentalhealth.med.va.gov>

Internet: <http://www.nepec.org>

VHA Mental Health Intensive Case Management (MHICM) Teams (June, 2004)

AL:	Birmingham	NE:	Omaha
	Tuscaloosa	NJ:	New Jersey (East Orange/Lyons)
	Tuskegee	NM:	Albuquerque
AR:	Little Rock	NY:	Albany
AZ:	Phoenix		Brooklyn
CA:	Greater Los Angeles		Buffalo
	Loma Linda		Canandaigua
	Long Beach		Hudson Valley (Montrose/Castle Pt.)
	Palo Alto		Northport
	San Diego		Syracuse
	San Francisco	NC:	Durham
CO:	Denver		Fayetteville
	Grand Junction		Salisbury
	Southern Colorado	OH:	Akron
CT:	West Haven		Chillicothe
DC:	Washington		Cincinnati
FL:	Gainesville		Cleveland
	Miami		Columbus
	Tampa		Dayton
	West Palm Beach		Mansfield
GA:	Atlanta		Youngstown
	Augusta	OR:	Portland
ID:	Boise	PA:	Coatesville
IL:	Chicago (West Side)		Lebanon
	Danville		Philadelphia
	North Chicago		Pittsburgh
IN:	Indianapolis	SC:	Charleston
	Northern Indiana (Marion/Ft. Wayne)		Columbia
IA:	Central Iowa (Knoxville/Des Moines)	TN:	Memphis
	Iowa City		Mountain Home
KS:	Eastern Kansas (Topeka)		Tennessee Valley
KY:	Louisville	TX:	Dallas
LA:	New Orleans		Houston
ME:	Togus		San Antonio
MD:	Baltimore		Waco
	Perry Point	UT:	Salt Lake City
MA:	Bedford	VA:	Hampton
	Brockton		Salem
MI:	Ann Arbor	WA:	American Lake
	Battle Creek		Seattle
	Detroit	WV:	Martinsburg
MN:	Minneapolis	WI:	Madison
	St. Cloud		Milwaukee
MS:	Gulf Coast (Biloxi/Gulfport)		Tomah
MO:	St. Louis	WY:	Sheridan
MT:	Fort Harrison		

What is the history and success of MHICM?

Mental Health Intensive Case Management (MHICM) programs represent the adaptation, within VA, of **assertive community treatment (ACT)**, a model developed in the 1970's by Arnold Marx, Leonard Stein, and Mary Ann Test in Madison, Wisconsin (1-6). ACT is one of the most heavily researched psychiatric services for people with serious mental illness, recently recommended as a state of the art intervention by the Schizophrenia Patient Outcomes Research Team (PORT) study (7-8). The intent of ACT developers was to make the comprehensive services and support of an inpatient unit available to outpatients in the community, integrated within a single team. ACT helps people to reduce psychiatric inpatient hospital use and improve community adjustment, quality of life, and satisfaction with services (9-12). Fidelity data further demonstrate that the success of a given ACT team is influenced by team adherence to the model, staff cohesiveness, and host agency support for outpatient treatment (13-16). In 1998, the National Alliance for the Mentally Ill (NAMI) adopted the Madison ACT model as a central element of its national anti-stigma campaign and many states and communities established ACT teams within their mental health systems.

Initially funded as a regional mental health demonstration program in 1987, nine original MHICM teams were compared via experimental design with standard VA aftercare services. Two-year findings revealed that MHICM veterans had significantly fewer hospital days and lower costs overall than veterans receiving standard VA treatment. Clinically, MHICM veterans scored significantly lower in psychiatric symptoms, and higher in functioning and satisfaction with services (17-18). Five-year outcomes showed sustained reductions in hospital use and improvements in psychiatric symptoms, functioning, and personal well-being for MHICM clients (18). Compared to a randomly assigned control group, 454 MHICM veterans averaged 158 fewer hospital days over five years. After accounting for program costs, the nine MHICM programs were responsible for VA cost reductions estimated at \$12.8 million, or \$2.6 million per year. The program was most successful at facilities that adhered to the model and showed performance improvements in other areas as well (16).

With the demonstration's success, 30 new MHICM teams were funded in 1994-95 as part of a national VA initiative that used successful teams as mentors for developing programs. The issue of VHA Directive 2000-034 prompted further program expansion with facility and network resources. System-wide monitoring data (FY 1997-03) indicate that: 1) MHICM programs serve veterans with severe, long-standing disabilities (90% psychotic diagnosis; 47% hospitalized for more than two years; mean of 88 hospital days in year preceding entry; 49% funds managed by representative payee); 2) MHICM staff provide frequent, continuous services in the community; 3) MHICM veterans show substantial reductions in hospital use (mean 54 days per veteran during the first twelve months of treatment) with commensurate reductions in inpatient costs (\$48,427 per veteran for 3,190 veterans treated for twelve months); and 4) MHICM veterans show significant improvements in symptoms, functioning, quality of life, and satisfaction after six months in the program (19-21).

MHICM offers a tested and effective model for community-based treatment and rehabilitation of veterans with serious mental illness who are high users of VA psychiatric inpatient resources. It is consistent with principles underlying VA's recent reorganization that emphasize novel outpatient delivery systems, enhanced accessibility, customer satisfaction, and cost savings. On the basis of MHICM's demonstrated effectiveness, the Mental Health Strategic Healthcare Group (MHSHG) and the VA Under Secretary's Special Committee for Severely Chronically Mentally Ill Veterans (SMI Committee) have encouraged NEPEC to assist VA facilities and networks with MHICM team development by providing training, technical assistance, and monitoring.

What are the minimum standards for an effective MHICM team?

Successful implementation of MHICM requires the following explicit administrative commitments, warranted by past experience and the relative resource intensity of MHICM services:

- Target veterans with **serious mental illnesses** and **impaired community functioning** (typically psychotic disorders, with or without accompanying substance abuse) who are **high utilizers of VA inpatient, residential, or crisis mental health services** (for whom traditional services have not resulted in stable community adjustment);
- Provide a dedicated staff of **at least four clinicians** including at least one nurse as well as psychiatric and office support. Larger teams staff have generally proven to be more effective and enduring.
- Promote **team cooperation and morale** to enhance efficiency and continuity (crucial to team success);
- Identify a **team leader** whose duties include liaison with VA and community representatives, supervision of MHICM staff, and delivery of clinical services in the community;
- Support **frequent client contact** and **delivery of clinical services in the community**, including in vivo assessment, medication delivery, skills training, and rehabilitation services.
- Assure **off-hours team access** for guidance of inpatient and emergency clinical staff;
- Provide **ancillary resources** for safe and efficient community services, including:
 - fixed, economical **team space**, at or near the medical center/clinic;
 - dedicated **vehicles** for daily community visits by each clinician;
 - dedicated **communication technology** (beepers, cell phones) to assure staff and client safety;
 - electronic **office technology** (computers, copier, answering machine, fax machine) for organizing, charting, and monitoring clinical work;
- Establish **integrated links** between the MHICM team and other mental health / rehabilitation services (inpatient, outpatient, and community) to enhance service coordination;
- Maintain a **clear line of authority**, with the team leader represented in the mental health service or product line; and
- Assure **quality and accountability through monitoring** of program effectiveness and cost.

Program Objectives and Principles

MHICM services are delivered by integrated, multidisciplinary teams and are based on the Substance Abuse Mental Health Services Administration (SAMHSA) ACT standards. MHICM teams seek to deliver high quality services that:

- provide intensive, flexible community support;
- improve health status (reduce psychiatric symptoms & substance abuse);
- reduce psychiatric inpatient hospital use and dependency;
- improve community adjustment, functioning, and quality of life;
- enhance satisfaction with services; and
- reduce treatment costs.

To accomplish these objectives, MHICM teams adhere to four core treatment elements:

- Intensity of Contact. High intensity of care primarily through home and community visits, with low caseloads (seven to fifteen veterans per clinician), allowing rapid attention to crisis and development of community living skills to prevent crisis in this exceptionally vulnerable population.
- Flexibility and Community Orientation. Flexibility and community orientation with most services provided in community settings and involving integration with natural support systems whenever possible (e.g., family members, landlords, employer).
- Rehabilitation Focus. Focus on rehabilitation through practical problem solving, crisis resolution, adaptive skill building, and transition to self-care and independent living where possible.
- Continuity and Responsibility. Identification of the team as a “fixed point of clinical responsibility” providing continuity of care for each veteran, wherever the veteran happens to be, for at least one year, with subsequent care subject to review of continuing need for intensive services.

VHA Directive 2000-034 establishes procedural guidelines for MHICM teams, operationalized in eight **minimum program standards** that serve to complement the critical performance monitors.

Minimum standard	Threshold value
➤ Percent of veterans with psychotic diagnosis at entry	(50% or more)
➤ Percent of veterans with 30 or more psychiatric inpatient days in year before entry	(50% or more)
➤ Mean adjusted face-to-face contacts per week/veteran	(1.0 or more)
➤ Ratio of veterans to clinical FTEE (mean caseload)	(7:1 to 15:1)
➤ Percent of veterans for whom at least 60% of contacts occur in community setting	(50% or more)
➤ Percent of veterans receiving psychiatric rehabilitation or skills training services	(25% or more)
➤ Percent of veterans discharged from MHICM program	(< 20%)
➤ Number of clinical service providers on the team	(4.0+ FTEE).

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**VA MENTAL HEALTH INTENSIVE CASE MANAGEMENT (MHICM) TEAM
IMPLEMENTATION CHECKLIST FOR FY 2004 ANNUAL REPORT**

September 15, 2004

This is a checklist of primary criteria and recommended operational standards for use in evaluating a current MHICM team. The checklist is based on current VA criteria for MHICM teams and published CARF standards for Assertive Community Treatment (ACT). All program elements should be in place within the first year of team development. **Please indicate whether each element is in place for your team at the end of FY 2004. If "No", briefly identify a reason or obstacle to be addressed. Record site identification data and general comments or questions below and return with your team's FY 2004 Annual Report by November 15, 2004. If you have questions about checklist items, please call Mike Neale Ph.D., VHA MHICM Project Director at 203.932.5711x3696. Thank you.**

Site Identification Data:

Submitting Facility/VISN: _____

Contact Person/Title: _____

Phone: _____ Fax: _____

Address: _____

Alternate Contact Person/Title: _____

Phone: _____ Fax: _____

Current MHICM FTEE? _____ Current MHICM team caseload? _____

Current MHICM vehicles? _____ Percent of staff time spent in community? _____

General Comments, Questions:

VA MENTAL HEALTH INTENSIVE CASE MANAGEMENT (MHICM) TEAM IMPLEMENTATION CHECKLIST

September 15, 2004

PRIMARY PROGRAM CRITERIA:

Element

In Place/Planned?

Why Not?

I. MHICM Target Population

MHICM veterans will meet all five of the following admission criteria:

1. diagnosis of severe and persistent mental illness (e.g., schizophrenia, bipolar disorder, major affective disorder, severe PTSD) with or without substance abuse; Yes__ No__
2. severe functional impairment (i.e., veteran is not currently capable of successful and stable maintenance in a community living situation or participation in necessary treatment without intensive support); Yes__ No__
3. inadequately served by or unable to achieve a stable community adjustment with conventional clinic-based outpatient treatment or day treatment; and Yes__ No__
4. high hospital use (i.e. 30 or more days or 3 or more episodes of psychiatric inpatient care in the year preceding MHICM admission). Yes__ No__
5. clinically appropriate for MHICM rather than inpatient care. Yes__ No__

II. MHICM Program Description

1. MHICM services will be delivered by an integrated, multi-disciplinary team with a minimum of 4.0 designated clinical FTE who provide services in the community. Yes__ No__

<u>Element</u>	<u>In Place/Planned?</u>	<u>Why Not?</u>
----------------	--------------------------	-----------------

II. MHICM Program Description (continued):

Core Elements (continued)

2. MHICM services will be characterized

by five core treatment elements, including:

- | | |
|---|------------|
| A. high intensity of care (primarily through home & community visits) | Yes__ No__ |
| with low caseloads (7-15 veterans per 1.0 clinical FTE), | Yes__ No__ |
| rapid attention to crisis and development of community living skills to prevent crisis; | Yes__ No__ |
| B. flexibility & community orientation with most services provided in community settings and involving natural support systems (family, landlord, employer) whenever possible; | Yes__ No__ |
| C. focus on rehabilitation through practical problem solving, crisis resolution, adaptive skill building, and transition to self-care and independent living where possible; | Yes__ No__ |
| D. identification of the team as a “fixed point of clinical responsibility” providing continuity of care for each veteran wherever s/he happens to be, for a prolonged period (initially 1 year, then based on periodic review of continuing need for services); and | Yes__ No__ |
| E. appropriate transition to standard care or lower intensity MHICM treatment when a veteran is: clinically stable, not abusing addictive substances, not relying on inpatient/ER services, capable of maintaining self in a community living situation, and independently participating in necessary treatments. | Yes__ No__ |

III. Accountability

Each MHICM team/clinician will:

- | | |
|--|------------|
| 1. Utilize national DSS identifiers to designate MHICM workload; | Yes__ No__ |
| 2. Maintain fidelity to MHICM operating principles and evidence-based clinical procedures; and | Yes__ No__ |

<u>Element</u>	<u>In Place/Planned?</u>	<u>Why Not?</u>
----------------	--------------------------	-----------------

III. Accountability (continued)

- | | | |
|--|------------|--|
| 3. Provide complete and timely MHICM monitoring information, including: | Yes__ No__ | |
| A. Standard Intake Data Form (IDF) completed with all new admissions, | Yes__ No__ | |
| B. Follow-Up Data Form (FDF) completed with each program veteran at 6 months and annually after entry, | Yes__ No__ | |
| C. Clinical Progress Report (CPR) completed by each veteran's primary case manager at 6 months and annually after entry, | Yes__ No__ | |
| D. FTE/Caseload Report completed monthly by the team leader, | Yes__ No__ | |
| E. Log of veterans treated, with entry / discharge dates, and dates for completing monitoring data. | Yes__ No__ | |
| F. Brief annual progress report on program developments, staffing, workload, projected/actual expenditures, including standards and fidelity checklists, due on November 15th each year, | Yes__ No__ | |

RECOMMENDED OPERATIONAL STANDARDS

IV. Staffing

- | | |
|---|------------|
| 1. Full-time team leader with master's level degree in mental health field (social work, psychology, nursing, counseling/guidance, rehabilitation) and 2000 hours (2 years) of post-degree treatment of people with serious mental illness. | Yes__ No__ |
| 2. Minimum of eight hours (.20 FTE) psychiatrist time for every 50 vets. | Yes__ No__ |
| 3. Minimum of 1.0 FTE RN and clearly designated, accessible nursing backup. | Yes__ No__ |
| 4. Minimum of three-fourths of clinical staff with at least a bachelor's degree in a mental health field. | Yes__ No__ |
| 5. Physician/nurses collaborate with other clinical staff to manage a system for prescribing/administering medications. | Yes__ No__ |
| 6. One or more staff designated to organize daily planning of team activities. | Yes__ No__ |
| 7. One or more staff with team chart auditing (QA) responsibilities. | Yes__ No__ |

<u>Element</u>	<u>In Place/Planned?</u>	<u>Why Not?</u>
----------------	--------------------------	-----------------

V. Hours of Coverage and Access

1. Team identifies regular hours of service with at least 8 hrs on 5 days/week and evening/weekend hours as appropriate. Yes__ No__
2. Hospital/ER staff have 24-hour, 365-day on-call access to team for crisis, admission, discharge consultation. Yes__ No__

VI. Communication and Daily Planning

1. Daily, M-F team meetings to review client status and organize/assign daily work of team. Rotated leadership. Yes__ No__
2. Integration of individual schedules for client contact (see treatment planning), emerging client needs, and team clinical responsibilities into daily work assignment. Yes__ No__
3. Recording of all client services and encounters, for purposes of auditing, workload credit, and evaluation. Yes__ No__
4. All staff remain accessible during work hours via beeper, pager, cellular phone. Yes__ No__

VII. Record-keeping

1. Charts contain basic sections: identifying data problem list; treatment plans/reviews; progress notes; intake/history; medications/lab results/consults; hospital summaries; clinical assessments/screenings; signed correspondence/releases; & consents/administrative. Yes__ No__
2. Progress notes within local guidelines re: frequency/format, including: assessments of: clinical status, danger to self/others; medication compliance; significant events & status changes; general goals/treatment planning; client/family education; location & frequency of contact; clear goals. Yes__ No__
3. Initial assessment done within 4 wks of entry & in chart, covering: psychiatric/psychological (with DSM-IV diagnosis), family/other supports, instrumental ADL, vocational, housing, medical/dental, substance abuse. Yes__ No__

<u>Element</u>	<u>In Place/Planned?</u>	<u>Why Not?</u>
----------------	--------------------------	-----------------

VII. Record-keeping (continued)

- | | |
|--|------------|
| 4. Treatment plan signed by multidisciplinary team in chart within 4 wks of entry and reviewed every 6 mos or as needed. | Yes__ No__ |
|--|------------|

VIII. Treatment Planning

- | | |
|---|------------|
| 1. Weekly meetings for in-depth review of client treatment plans (1-2 clients per hour mtg), including current status & priorities, strengths & needs, short & long-term goals, staff activities & assignments. | Yes__ No__ |
| 2. Multi-disciplinary treatment review schedule determined weeks ahead. | Yes__ No__ |
| 3. Clear leadership of meetings. | Yes__ No__ |
| 4. Problems, goals, plans, & priorities all specific & interpretable, with clear staff roles and activities. | Yes__ No__ |
| 5. Treatment plan tasks and goals copied to client weekly/monthly schedule, for use in daily planning. | Yes__ No__ |
| 6. Treatment plan reviewed with and co-signed by client. | Yes__ No__ |

IX. Treatment and Rehabilitation Services

- | | |
|--|------------|
| 7. Primary clinician assigned for each client, although team provides multi-disciplinary treatment for each client. | Yes__ No__ |
| 8. Two or more staff with complementary skills / training identified on treatment plan to provide clinical services for each client. | Yes__ No__ |
| 9. Team provides a broad range of services for assigned clients as clinically indicated: advocacy; coordination; assessment & monitoring of symptoms/stressors/risks/ coping/med compliance/activities/skill levels; planning; help/skills training for daily tasks (ADLs, shopping); family support/education, and crisis intervention (see treatment plans). | Yes__ No__ |
| 10. Team initially sees each client for 2-3 substantial contacts per week on average with more frequent direct or phone contact as clinically indicated. | Yes__ No__ |

<u>Element</u>	<u>In Place/Planned?</u>	<u>Why Not?</u>
----------------	--------------------------	-----------------

IX. Treatment and Rehabilitation Services (continued)

- | | |
|---|------------|
| 11. On a typical working day, at least 20% of clients are seen. | Yes__ No__ |
| 12. Clinicians spend 50-75% of work time providing treatment / rehabilitation services in community settings. | Yes__ No__ |
| 13. Team serves as fixed point of clinical responsibility with a long-term commitment to care of each client as clinically indicated. Initial expectation is for at least one year. | Yes__ No__ |
| 14. Team assumes primary clinical responsibility for assigned clients. | Yes__ No__ |

X. Assessments

- | | |
|--|------------|
| 1. Assessments in charts (see IV-19). | Yes__ No__ |
| 2. Assessments completed by members of multi-disciplinary team, considering specific training or expertise:
Psychiatric..psychiatrist
Vocational..team professional staff,
voc rehab specialist
ADL..team professional staff
Leisure time..team professional staff
Family..team professional staff
Medical..RN/MD | Yes__ No__ |

XI. Admission / Discharge Criteria

- | | |
|---|------------|
| 1. Admission criteria are clearly stated in policy statement and communicated to referring services, including client willingness to participate (i.e., signed releases, consents). | Yes__ No__ |
| 2. Criteria for discharge or transition to lower intensity services are clearly stated in policy statement, including: clinically stable, not abusing addictive substances, not relying on extensive inpatient or emergency services, capable of maintaining self in a community living situation, and independently participating in necessary treatments. | Yes__ No__ |

<u>Element</u>	<u>In Place/Planned?</u>	<u>Why Not?</u>
XII. VA, Community Agency, Client Relationships		
1. Meetings are held periodically with leaders of VA & community services to introduce MHICM staff, review policies & procedures, and gain cooperation. E.g., <u>VA</u> : inpatient/outpatient mental health units/services, ER/admitting staff, security, engineering, pharmacy, volunteer service, patient advocate, benefits counselor, VSOs. E.g., <u>Community</u> : ER, psychiatric/detox units, psychosocial clubs, vocational rehabilitation, police, housing authority, residential facilities, crisis intervention. Yes__ No__		
2. If vocational rehabilitation staff are not on team, liaison exists with voc rehab service/agency to perform assessments, provide training & support. Yes__ No__		
XIII. National Evaluation Requirements		
1. Clients are included in planning and evaluating team services, as clinically appropriate. Yes__ No__		
2. Team completes a brief annual progress report on program developments, staffing, workload, projected/actual expenditures, including standards and fidelity checklists, due on November 15th each year. Yes__ No__		
3. Each team maintains a log of veterans treated, with entry/discharge dates, and dates for completion of monitoring data. Yes__ No__		
4. Designated clinician completes standard outcomes monitoring form at intake and 6 and 12 months after entry, and annually thereafter, for each veteran. Yes__ No__		
5. Designated clinician or team completes clinical progress report form every 6 months after entry, for each veteran. Yes__ No__		

Assertive Community Treatment Fidelity Scale

Please complete all items without an "X" for this edited scale.
The scale and contact sheet are on six pages.

Form A (1)

VA Facility Name: _____

1. Five-Digit Facility code _____ (6)

Local name of the Team/Program:

_____ (8)

2. Target population (*list one letter from the categories below*) (9)

A. Seriously mentally ill veterans (non substance abuse)

B. Seriously mentally ill veterans (primarily substance abuse)

X3. Item deleted (leave response areas blank). x_____x (10)

x_____x (12)

X4. Item deleted (leave response areas blank).

x_____x (13)

X5. Items deleted (leave response areas blank).

x_____x (17)

x_____x (21)

x_____x (25)

x_____x (29)

x_____x (33)

x_____x (37)

x_____x (41)

6. Regarding your clients:

x_____x (43)

A. How many veterans are currently in treatment in this program? (46)

B. How many veterans is the program designed to treat when it is operating at full capacity? (49)

X7. Item deleted (leave blank). x\$_____x (56)

X8. Items deleted (leave response areas blank).

x_____x (59)

x_____x (62)

x_____x (65)

9. In what year was the program first implemented? 19 or 20 ____ ____ (67)

Answer the following with the categories directly beneath the question.

10. What is the caseload of your program? (68)

- A. 10 or fewer clients per clinician
- B. 11—20 clients per clinician
- C. 21—34 clients per clinician
- D. 35—49 clients per clinician
- E. 50 or more clients per clinician

11. What percent of clients have contact with more than one staff member in a given week? (69)

- A. 90% or more
- B. 64—89%
- C. 37—63%
- D. 10—36%
- E. 10% or fewer

12. How frequently do the team members meet to plan or review services for each client? (70)

- A. Program meets 4—5 days/week and usually reviews each client, even if only briefly
- B. Program meets 2—3 days/week and usually reviews each client, even if only briefly
- C. Program meets 1 day/week and usually reviews each client, even if only briefly
- D. Program meets 1 day every other week and usually reviews each client, even if only briefly
- E. Program meets 1 day per month or less and usually reviews each client, even if only briefly

13. How much of the time does the program's supervisor /director/coordinator provide services to clients? (71)

- A. Normally, at least 50% of the time
- B. Normally, between 25% and 50% of the time
- C. Routinely as backup, or normally less than 25% of the time
- D. On rare occasions as backup
- E. Supervisor provides no direct services to clients

14. How much staff turnover has the program experienced in the *past two* years? (72)

- A. Less than 20%
- B. 20—39%
- C. 40—59%
- D. 60—80%
- E. More than 80%

15. At what percent of full staffing has the program been operating for the *past twelve* months? (73)

- A. 95% or more
- B. 80—94%
- C. 65—79%
- D. 50—64%
- E. less than 50%

16. Does the program have a defined target population and explicit admission criteria? (74)
- A. The program actively recruits a defined population and all cases comply with explicit admission criteria.
 - B. The program typically actively seeks and screens referrals carefully, but occasionally bows to organizational pressure.
 - C. The program makes an effort to seek and select a defined set of clients, but accepts most referrals.
 - D. The program has a generally defined mission, but the admission process is dominated by organizational convenience.
 - E. The program has no set criteria and takes all types of cases, as determined outside the program.
17. Over the past six months, the highest monthly *intake* rate (that is, how many new clients have been admitted to the program) per month has been:..... (75)
- A. No greater than 6 per month
 - B. 7—9 per month
 - C. 10—12 per month
 - D. 13—15 per month
 - E. 16 or more per month
18. Which of the following five types of treatment services does your program offer? (Check all that apply)
- A. Counseling/psychotherapy (76)
 - B. Housing support (77)
 - C. Substance abuse treatment (78)
 - D. Employment/ vocational rehabilitation (79)
 - E. Rehabilitative services (80)
19. What role does the program have in providing crisis services to its clients?..... (81)
- A. The program provides 24 hour coverage
 - B. The program provides emergency service backup; e.g., program is called, makes a decision about need for direct program involvement.
 - C. The program is available by telephone, predominately in a consulting role.
 - D. Emergency service has program-generated protocol for program clients.
 - E. The program has no responsibility for handling crises after hours.
20. In what percent of hospital admissions of program clients are staff involved in the decision to admit? (82)
- A. 95% or more
 - B. 65—94%
 - C. 35—64%
 - D. 5—34%
 - E. 4% or less

21. In what percent of hospital discharge plans for program clients are program staff involved in developing the plan (planned jointly or in cooperation with the hospital staff)? (83)
- A. 95% or more
 - B. 65—94%
 - C. 35—64%
 - D. 5—34%
 - E. 4% or less
22. What percent of program clients are discharged from the program within one year of program entry? (84)
- A. 6% or fewer
 - B. 6—17%
 - C. 18—37%
 - D. 38—90%
 - E. 91% or more
23. What percent of time with clients is spent in the community (rather than in the office)? (85)
- A. 80% or more
 - B. 60—79%
 - C. 40—59%
 - D. 20—39%
 - E. 19% or less
24. What percent of the team caseload is retained over a twelve month period? (86)
- A. 95% or more
 - B. 80—94%
 - C. 65—79%
 - D. 60—64%
 - E. 59% or less
25. Does the program use street outreach and/or legal mechanisms (such as representative payees, probation/parole, outpatient commitment) to engage clients, as clinically indicated? (87)
- A. The program has a strategy that includes street outreach and legal mechanisms whenever appropriate
 - B. The program has a strategy and uses most of the mechanisms that are available
 - C. Program attempts outreach but uses legal mechanisms only as convenient
 - D. Program makes initial attempts to engage but generally focuses efforts on most motivated clients.
 - E. The program almost never uses street outreach.
26. On average, how much service time does each client receive per week? (88)
- A. 2 hours or more
 - B. 85—119 minutes
 - C. 50—84 minutes
 - D. 15—49 minutes
 - E. 14 minutes or less

27. On average, how many service contacts are made with each client per week? _____ (89)
- A. 4 or more per week
 - B. 3 per week
 - C. 2 per week
 - D. 1 per week
 - E. less than 1 per week
28. For clients who have a support network, such as family, landlords, or employers, on average how many staff contacts are made with members of support network per month? _____ (90)
- A. 4 or more per month
 - B. 3 per month
 - C. 2 per month
 - D. 1 per month
 - E. less than 1 per month
29. For clients with a substance use disorder, how many minutes per week of substance abuse treatment do they receive from program staff? _____ (91)
- A. 24 minutes per week or more
 - B. 17—23 minutes per week
 - C. 10—16 minutes per week
 - D. 3—9 minutes per week
 - E. 2 minutes per week or fewer
30. What percent of clients with a substance use disorder attend group treatment that is provided by program staff? _____ (92)
- A. 50% or more
 - B. 35—49%
 - C. 20—34%
 - D. 5—19%
 - E. 4% or fewer
31. For clients with both serious psychiatric illness and a substance use disorder, to what extent does the program employ an integrated “dual disorders” model that is stage-wise, non-confrontational, follows behavioral principles, considers interactions of mental illness and substance abuse, and has gradual expectations of abstinence) ? . _____ (93)
- A. The program is fully based on such DD treatment principles, with treatment provided by program staff
 - B. The program primarily uses such a DD model, with some substance abuse treatment provided outside the program
 - C. The program uses a mixed model, including both DD and non-DD principles
 - D. The program uses primarily a traditional model
 - E. The program is fully based on a traditional model
32. What DSS Identifiers (formerly called “stop codes”) are used to document the work of this program?
- A. First DSS identifier (typically 552) _____ (96)
 - B. Second DSS identifier (typically 546) _____ (99)
 - C. Third DSS identifier (if applicable) _____ (102)

Contact person or Person completing this form:

Name _____

Telephone number (with area code and extension): () _____ x _____

Fax number: () _____

Email (Internet) Address: _____

Address information (street, building, mail stop, city, state, zip):

If you have questions about the survey or items, please contact:

Mike Neale PhD: (203) 932-5711 x 3696

General comments accompanying the survey are welcome.

Please attach the survey to the Annual Report.

Appendix C

Outlier Review Request and Form

July 26, 2005

Director, NEPEC / VA MHICM Project Director

FY 2004 Performance and Minimum Standards Outlier Review

MHICM Program Directors, Clinical and Clerical Staff

1. DRAFT Tables 2-1 to 2-32 for the FY 2004 MHICM National Performance Monitoring Report, have been placed on the NEPEC intranet page, <http://vawww.nepec.mentalhealth.med.va.gov/>, for field review, along with Appendix D which provides a legend for each table and variable. We are also forwarding a copy of the relevant files by Outlook e-mail. As with the FY 2003 Report, MHICM performance and critical monitors are listed in Table 2-1 and data are presented in Adobe Reader (.pdf) formatted Tables 2-2 to 2-32. You may need to download a more recent version of Adobe Acrobat Reader to view or print them. A download link for the software is available on the NEPEC home page (see above). Please consult your local IRM office if necessary.
2. Please review your team's data on all tables and complete and return an outlier review for any shaded value on the monitoring and minimum standards tables. Outlier values are those for which a team's value exceeds the threshold for a critical monitor. Outliers in the *desired* direction, underlined in **bold**, require no response. Outlier values in the *undesired* direction are shaded in Tables 2-2 to 2-25 and outlined in summary tables (2-27 to 2-32) for each of the four monitoring domains (structure, client, service delivery, outcome) and the eight Minimum Program Standards.
3. Each team is asked to review team values on all tables for accuracy and to identify each monitor or minimum standard for which the team is an outlier. For each outlier in the **undesired** direction, please complete an outlier review summary: 1) Identify the monitor; 2) Select a reason for outlier status; and 3) provide a brief explanation or summary of plans to correct the team value. Teams with outlier values in FY 2004 may want to consider adjusting team resources or operation to bring performance within the desired range for FY 2005.
4. Only negative (shaded) outliers for **critical monitors** indicated in the Outlier Summary Tables {Tables 2-27 through 2-32} require formal outlier response using the outlier review form provided with the FY 2004 draft tables. Currently, that does not include outliers indicated for ACT Fidelity, Housing Independence, 6/12/18/24-month hospital use, IADLs, or Service Satisfaction. We have provided outlier feedback on these additional variables to assist your team in planning and to indicate areas where changes may be necessary to improve performance
5. If you have questions or comments about a particular measure or criterion value, please note them on the review form or send them separately. Please refer questions about the tables or outlier review to Mike Neale (203.932.5711x3696) and return the completed review forms to NEPEC by Fax (203.937.4762) or mail (NEPEC/182, VA Connecticut HCS, 950 Campbell Avenue, West Haven, CT 065176), by **Friday, April 29th, 2005**.
6. Thank you all for your dedicated efforts on behalf of veterans with serious mental illness.

(Signed)

Robert Rosenheck, M.D.

(Signed)

Michael Neale, Ph.D.

MHICM Outlier Review, FY 2004

This form asks the 71 VA Mental Health Intensive Case Management (MHICM) teams that are included in the FY 2004 MHICM National Performance Monitoring Report to respond to their identification as an outlier on one or more critical performance monitors and minimum program standards, based on the **DRAFT FY 2004 performance tables**. Please refer to the **DRAFT tables to identify all critical monitors and standards for which your team's performance fell outside desired values for an MHICM team**. For each outlier in the undesired direction, please select a primary reason and explain the situation and/or plans for remedy below.

Please submit your responses to Mike Neale PhD, VA MHICM Project Director at NEPEC, by Friday, April 29th, 2005. You may fax the form to 203.937.4762, mail it (Mike Neale PhD, NEPEC/182, VA Connecticut, 950 Campbell Avenue, West Haven, CT 06516, or respond via Outlook. If you have questions about specific values or the outlier review, please call Mike at 203.932.5711 x3696 or send an Outlook message. Thanks.

If you need additional pages, please make copies of the second page of this form.

MHICM SITE: _____ VA Station Code #: _____

Person completing this report: _____

Phone number: (_____) _____ ext. _____

Monitor/standard: _____

Reason for outlier status: *Please select the most important reason. If more than one applies, indicate in the narrative.*

_____ a. Legitimate differences in this site's team that do not conflict with national program goals.

_____ b. Local policies at this site that may conflict with national program goals.

_____ c. Problems in program implementation for which corrective action has been taken.

_____ d. Problems in program implementation for which corrective action has since been planned.

_____ e. Problems in program implementation for which corrective action has not yet been planned.

Explain: _____

Monitor/Standard: _____

Reason for outlier status: *Please select the most important reason. If more than one applies, indicate in the narrative.*

- _____ a. Legitimate differences in this site's team that do not conflict with national program goals.
- _____ b. Local policies at this site that may conflict with national program goals.
- _____ c. Problems in program implementation for which corrective action has been taken.
- _____ d. Problems in program implementation for which corrective action has since been planned.
- _____ e. Problems in program implementation for which corrective action has not yet been planned.

Explain: _____

Monitor/standards: _____

Reason for outlier status: *Please select the most important reason. If more than one applies, indicate in the narrative.*

- _____ a. Legitimate differences in this site's team that do not conflict with national program goals.
- _____ b. Local policies at this site that may conflict with national program goals.
- _____ c. Problems in program implementation for which corrective action has been taken.
- _____ d. Problems in program implementation for which corrective action has since been planned.
- _____ e. Problems in program implementation for which corrective action has not yet been planned.

Explain: _____

List of Critical Monitors and Minimum Standards for Outlier Review, FY 2004 Draft Tables

Critical Monitor	Table	Column	MS#
<i>Team Structure (Table 2-28)</i>			
1. FTE Unfilled: more than 6 months (Y)	2-5	7	
2. Unassigned Medical Support: MD and/or RN (Y)	2-6	3	
3. Unassigned Medical Support: MD and/or RN (Y)	2-6	4	
4. Caseload Size: Mean Ratio Clients per Clinical FTEE (LT 7, GT15)	2-6	7	4
5. Team Size: # Full-time Clinical Staff (4.0+FTEE)	2-5	6	8
<i>Client Characteristics (Table 2-29)</i>			
6. % Clients with GTE 30 Days Hospital Yr Pre (LT 50%)	2-10	5	2
7. % Clients with Psychotic Diagnosis at Entry (GT 50%)	2-10	6	1
8. Mean GAF at Entry Exceeds 50 (GT 50)	2-11	6	
<i>Clinical Process (Table 2-30)</i>			
9. Tenure: % Clients Discharged (>20%)	2-12	5	7
10. Intensity: % Clients Seen GTE 1 Hour per wk (LT 1 Hr/Wk)	2-13	6	
11. Location: % Clients seen 60% or more in community (LT 50%)	2-13	7	5
12. Frequency: # Adjusted face-to-face contacts/Wk (LT 1/Wk)	2-14	9	3
13. Team provides Psychiatric Rehabilitation Services (LT 25% Vets)	2-15	6	6
<i>Client Outcome (Table 2_31)</i>			
14. Hospital Use: 365 Days % Change MH Days (Post-Pre Low)	2-18a	5	
15. Reported Symptoms: % Change (BSI) (High)	2-20	5	
16. Observed Symptoms: % Change (BPRS) (High)	2-19	5	
17. Quality of Life: % Change (QOL) (Low)	2-23	7	

MS#: Critical Performance Monitor is also a Minimum Standard (Table 2-32)

List of MHICM Teams Included in the FY 2004 Performance Monitoring Report

VISN VISN	Station Code STA5A	Facility Name Location
1	518	Bedford
1	523A5	Brockton
1	402	Togus
1	689	West Haven
2	528A8	Albany
2	528	Buffalo
2	528A5	Canandaigua
2	528A7	Syracuse
3	630A4	Brooklyn
3	620	Montrose
3	561A4	New Jersey
3	632	Northport
4	542	Coatesville
4	646A5	Pittsburgh
5	613	Martinsburg
5	512A5	Perry Point
6	565	Fayetteville
6	590	Hampton
6	658	Salem
6	659	Salisbury
7	508	Atlanta
7	509	Augusta
7	521	Birmingham
7	679	Tuscaloosa
7	619A4	Tuskegee
8	573	Gainesville
8	546	Miami
8	673	Tampa
10	538	Chillicothe
10	539	Cincinnati
10	541	Cleveland
10	757	Columbus
10	552	Dayton
10	541B2	Youngstown
11	506	Ann Arbor
11	515	Battle Creek
11	553	Detroit

11	610	Northern Indiana
12	537	Chicago-West Side
12	607	Madison
12	695	Milwaukee
12	556	North Chicago
12	676	Tomah
15	657A0	St. Louis
15	677	Topeka
16	520	Gulf Coast
16	580	Houston
16	598	Little Rock
16	629	New Orleans
17	549	Dallas
17	685	Temple (Waco)
18	501	Albuquerque
18	644	Phoenix
19	554	Denver
19	575	Grand Junction
19	660	Salt Lake City
19	666	Sheridan
19	567	Southern Colorado
20	663A4	American Lake
20	531	Boise
20	648	Portland
20	663	Seattle
21	640	Palo Alto
21	662	San Francisco
22	691	Greater Los Angeles
22	664	San Diego
23	636A8	Iowa City
23	636A7	Knoxville
23	618	Minneapolis
23	636	Omaha
23	656	St. Cloud

Appendix D

Legend for MHICM Summary Report Tables

This appendix details the source and creation of variables included in national NEPEC monitoring of the 71 MHICM teams included in the 8th MHICM National Performance Monitoring Report for FY 2004. Site-by-site values for these variables are described in Chapter 2 of the report and presented in Tables 2-1 to 2-26, Figures 2-1 to 2-6 and Appendices E-H. Text and tables are organized into domains of program structure, client characteristics, service delivery, clinical outcomes, and unit costs. Data for this report represent 4,761 veterans who received services and for whom follow-up data were available completed between October 1, 2003 and September 30, 2004.

Monitors for original MHICM teams are based on data for reduced numbers of recently entered clients and may not accurately represent values for their entire client population. For each variable, outliers were identified by tests of significance ($p < 0.05$) between the least square mean of the change score for a given team and the median site score. Outliers in undesired direction are indicated by **shaded** values and in the desired direction by **bold, underlined** values. Outliers are **boxed** in summary Tables 2-27 through 2-32. Team responses to outlier values are reported in Table 2-33. **Note: Seventy-one teams with 10 or more veterans who had Baseline (IDF) and Follow-up (FDF/CPR) data from “30 series” forms were included in analyses for this report.**

TO ASSIST WITH INTERPRETATION, SEE THE ACRONYM LIST AT THE END OF THIS APPENDIX

TABLE SUMMARY DATA (AT THE BOTTOM OF MOST TABLES)

ROW HEADING	COMPUTATION DESCRIPTION
ALL SITES	Overall sum or mean across all veterans for all MHICM teams included in the analysis.
SITE AVERAGE	Team mean or average for the 71 site values presented in the table above.
SITE STD. DEV.	Standard deviation from the mean for all site values presented in the table above.

Table 2-1: VA MHICM Program Monitors

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
Monitoring Domain	Area addressed by monitoring variable (Structure/Client/Process/Outcome/Cost).
Program Monitor	Monitoring variable derived from MHICM interviews, ratings, or centralized VA data.
Unit	Unit of measurement for monitoring variable.
Report Table	Number of report table presenting data on a given monitoring variable.
Program Objective	Program objective (1-6) addressed by monitoring variable (see Appendix B).
Critical Monitor	Indicator of critical status for comparison and outlier identification.

Table 2-2: MHICM Programs through FY 2004

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
VISN	Veterans Integrated Service Network number.
Site Name	Name/Location of host facility or healthcare system.
Site Code	Host Facility Station Code, including 5-digit station code numbers for consolidated facilities.
Site Type	GM&S: General Medical and Surgical facility; NP: Former Neuro-Psychiatric facility.
MHICM Startup Year	Year team began accepting veteran clients.

Table 2-3: Allocated Staff and Funds (Original Dollars)

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
Allocated FTE	Source: MSHSG Resource tables
Personal Service	Original allocation of positions for MHICM services (excludes local contributions).
All Other	Original allocation of recurring Personal Service funds (salary and benefits).
Admin. Support	Original allocation of recurring All Other funds (supplies, leased equipment).
Total Program \$	Original allocation of recurring Administrative Support funds (use at local discretion).
	Original allocation of Total funds.
<u>Row Heading</u>	<u>Computation Description</u>
All Sites	Overall sum or mean across all individuals or MHICM teams included in the analysis.
Site Average	Team mean or average for the 71 site values presented in the table above.
Site S.D.	Standard deviation from the mean for all site values presented in the table above.

Table 2-4: FY 2004 Program Expenditures

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: FY 2004 site-generated progress reports.
FY 04 Filled FTE	FY 2004 reported MHICM filled FTE.
FY 04 P/S Expend.	FY 2004 reported expenditure of MHICM Personal Service funds.
FY 04 AO Expend.	FY 2004 reported expenditure of MHICM All Other funds.
FY 04 Total Expend.	FY 2004 reported Total expenditure of MHICM funds.

Table 2-5: Utilization of Staff Resources

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: September, 2004 Monthly FTE/Caseload Report
Allocated FTE	MHICM FTE ceiling, adjusted to include locally funded positions.
FY Filled FTE	MHICM positions reported filled as of September 30, 2004.
% FTE Utilized	Percent MHICM positions reported filled as of September 30, 2004.
Sept. Clinical FTE	Positions available to provide MHICM case management services as of September 30, 2004.
	Shaded values are below the MHICM standard of 4.0 Clinical FTEE.
FTE Unfilled GTE 6 mos.	Yes = one or more MHICM positions unfilled for 6 or more months.
	Shaded values had one or more positions unfilled for 6 months or more.
Assigned non-MHICM	Yes = one or more MHICM staff detailed to non-MHICM work.
	Shaded values have one or more staff detailed to non-MHICM work..

Table 2-6: Clinical Staff and Caseload

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: September, 2004 monthly FTE/Caseload Summary
Medical Support MD	Y = psychiatrist assigned to MHICM team.
	Shaded values indicate the team does not have an assigned psychiatrist.
Medical support RN	Y = nurse-case manager assigned to MHICM team.
	Shaded values indicate the team does not have an assigned nurse-case manager.
Clinical FTE	Positions available to provide MHICM case management services.
9/04 Total # Vets	MHICM veterans as of September 30, 2004.
9/04 Caseload / Clin FTE	Average number of veteran clients per clinical FTE.
	Shaded values indicate the mean caseload is outside MHICM standard range of 7:1 to 15:1.
Target Caseload	<u>Min</u> : minimum caseload ratio of 7 clients per clinical FTE (VHA Directive 2000-034).
	<u>Max</u> : maximum caseload ratio of 15 clients per clinical FTE (VHA Directive 2000-034).

Table 2-7: Demographic Characteristics of Veterans at Intake

<u>Column/Row Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: Initial Data Form (IDF), Form 34.
Overall	All sites combined (N=71 teams in FY 2004 are represented in this report.)
GM&S	General medicine & surgery facilities (N=46 teams).
NP	Former neuro-psychiatric facilities (N=25 teams).
Gender	% MHICM veterans who are male or female (34: Face sheet).
Age	Mean age of MHICM veterans (34: Face).
Race	% MHICM veterans from different racial/ethnic backgrounds (34: Face).
Marital status	% MHICM veterans with different marital histories (34: Face sheet).
Combat exposure	% MHICM veterans reporting exposure to combat (34: #25).
Employment Last 3 yrs	% MHICM veterans with different employment histories in past 3 years (34: #31).

Table 2-8: Entry Criteria Information

<u>Row Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: IDF 34.
Mn hospital days 1 yr pre	Mean days spent in VA hospital; year before entry (34: #17).
Inpt psych unit referral	% MHICM veterans referred for MHICM treatment directly from inpatient unit (34: #16).
Primary psych diagnosis	% MHICM veterans with a DSM-IV psychiatric diagnosis at entry (34: #21).
GTE 30 days in hospital	% MHICM veterans with 30+ psychiatric hospital days in year before entry (34: #17; PTF). <i>GTE means "Greater than or equal to."</i>
Dual diagnosis at entry	% MHICM veterans with co-morbid substance abuse diagnosis at entry (34: #21).
Diagnosis	% MHICM veterans meeting various diagnostic criteria at entry (34: #21).
Disability/Pension	% MHICM veterans receiving any compensation or disability funds (34: #26-9).
SC Disability	% MHICM veterans with VA service-connected disability (34: #26; Face).
NSC Pension	% MHICM veterans receiving VA non-service connected pension (34: #26; Face).
SSI	% MHICM veterans receiving Social Security Supplemental Income (34: #27).
SSDI	% MHICM veterans receiving Social Security Disability Income (34: #28).
Payee	% MHICM veterans with a designated representative payee for funds (34: #29).

Table 2-9: Receipt of Disability Compensation or Pension Income

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: IDF 34.
VA Compensation %	% MHICM veterans receiving VA service-connected compensation (34: #26).
NSC Pension %	% MHICM veterans receiving non-service-connected pension (34: #26).
SSI %	% MHICM veterans receiving Social Security Supplemental Income (34: #27).
SSDI %	% MHICM veterans receiving Social Security Disability Income (34: #28).
Rep Payee %	% MHICM veterans with a designated representative payee for funds (34: #29).
Any Disability %	% MHICM veterans receiving any compensation/disability pension (34: #26-29).

Table 2-10: Entry Criteria Information by Site

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: IDF 34.
Lifetime Hosp GT 2 yrs	% MHICM vets reporting lifetime psychiatric hospital use GT 2 yrs (34: #190).
Years since 1st Hosp	Mean years since first psychiatric hospitalization (34: #47).
GTE 30days Hosp. yr pre	% MHICM veterans with 30+ VA hospital days; year before entry (34: #17). Shaded values: Less than 50% of veterans have 30+ hospital days prior to entry. Bold values: 100% of veterans have 30+ hospital days in year prior to entry.
Psychotic Dx at Entry	% MHICM veterans with psychotic diagnosis at entry (34: #22), including: schizophrenia, schizo-affective disorder, other psychosis, and bipolar disorder. Shaded values: Less than 50% of veterans with diagnosis of psychosis at entry. Bold values: 100% of veterans have diagnosis of psychosis at entry.
Dual diagnosis	% MHICM veterans with co-morbid substance abuse diagnosis at entry (34: #21).

Table 2-11: Clinical Status at Entry

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: Initial Data Form (IDF), Form 34.
Inpatient at Entry	% veterans entering MHICM from inpatient status (34: #16; 24: na).
Low IADL	% MHICM veterans scoring 1 or 2 on one of four Form 34 IADL items (#121,123-125).
BPRS Mean	Mean BPRS Total score (sum 18 items) at entry (34: #265-283). Note: "1" added to each BPRS item to conform with current reporting conventions.
GAF Mean	Average GAF score at entry (34: #284). Shaded values: Mean GAF score at entry is 50 or higher.

Table 2-12: MHICM Program Tenure

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: Clinical Progress Report (CPR), Form 39; NEPEC Access files.
Total Vets	# MHICM veterans with FDF between 10/1/02 and 9/30/04 (Access/SAS).
Vets Discharged #	# Follow-up veterans discharged by program as of September 30, 2004 (Access).
Vets Discharged %	% Follow-up veterans discharged as of September 30, 2004 (#DC'd / Total # Vets). Shaded values: More than 20% of team veterans were discharged during the fiscal year.
Mean Days in Program	Average # Days in MHICM per veteran (FDF date minus IDF date).

Table 2-13: Pattern of Service Delivery

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: Clinical Progress Report (CPR), Form 39; NEPEC Access files.
Total Vets	# MHICM veterans in FY 2004 (Access/SAS).
Contact Frequency	Face-to-face: % MHICM veterans with weekly or more frequent contact (39: #40). Telephone: % MHICM veterans with weekly or more frequent contact (39: #41).
Intensity	% MHICM veterans with GTE one hour of weekly contact (39: #45). Shaded values: Less than half of clients have weekly or more frequent contact. Bold values: More than 78% of clients have weekly or more frequent contact.
Location	% MHICM veterans with GTE 60% of contacts in the community (39: #37). Shaded values: Less than half of veterans have 60% or more of contact in the community. Bold values: 98-100% of clients have 60% or more of their contact in the community.
All Site v. Site Average	Mean value for all vets combined (N=4,761) v. site scores (N=71) in the table.

Table 2-14: Outpatient Clinic Visits

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: VA Outpatient Clinic (OPC) stops reported b/w 10/1/01 and 9/30/03.
Total Vets seen	# MHICM veterans with a MHICM stop code during FY 2004 (Access/SAS).
Mean contacts/Vet: 12mo.	Total: Avg. sum all MHICM encounters recorded under DSS identifiers 546 & 552 per vet. Telephone: Avg. sum telephone encounters recorded under DSS identifier 546 per vet. Face-Face: Avg. sum face-to-face encounters recorded under DSS identifier 552 per vet.
Amount time in program	Mean proportion of period (10/1/03-9/30/04) veterans spent in MHICM (per site). Used to standardize all veterans and sites at 12 months. of program participation.
Adjusted face-face/vet	Mean face-to-face contacts, divided by the team's amount of time in program.
Adjusted face-to-face contacts/wk/vet	Mean face-to-face contacts, adjusted for each team's amount of time in program, then divided by 52 weeks to get a contacts per week value. Shaded values: Mean of team contact is less than 1.0 per week per veteran. Bold values: Mean of team contact exceeds 1 standard deviation above the mean.

Table 2-15A & B: Therapeutic Services

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
Follow-up Vets	Source: Clinical Progress Report (CPR), Form 39. # MHICM veterans with FDF between October 1, 2003 and September 30, 2004.
Supportive Contact	% veterans receiving supportive contact services from MHICM (39: # 13;).
Active Monitor	% veterans receiving active monitoring services from MHICM (39: #15).
Rehabilitation	% veterans receiving rehabilitation services from MHICM (39: #16). Shaded values: Less than 25% of veterans receive rehabilitation services. Bold values: Percent of clients receiving rehabilitation services exceeds 1 standard deviation above the mean.
Psychother Relationship	% veterans receiving psychotherapeutic treatment from MHICM (39: #18).
Social/Rec Activities	% veterans in social/recreational activities organized by MHICM (39: #19).
Crisis Intervent	% veterans receiving crisis intervention services from MHICM (39: #23).
Medicatr Mgmt	% veterans whose medications were managed by MHICM (39: #24).
Medical Screen	% veterans screened for or treated for medical problems by MHICM (39: #25).
Seen for Sub. Abuse	% veterans receiving substance abuse treatment from MHICM (39: #26).
Housing Support	% veterans assisted with locating or managing housing by MHICM (39: #27).
Vocational Support	% veterans assisted with locating or maintaining a job by MHICM (39: #30).

Table 2-16: Client-Rated Therapeutic Alliance

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	IDF 34; Follow-up Data Form (FDF), Form 37. MHICM alliance at 6 mos. was compared with pre-entry alliance with primary clinician.
Pre-Entry N	MHICM veterans with IDF entry interview data on this measure.
Pre-Entry Mean	Average score for this measure at entry (34: #219-225).
Follow-up Mean	Average score for this measure at 6 months (37: #179-185), adjusted for site, time in program, baseline value, and eleven other baseline covariates.
Change at Follow-up	Least squares mean derived from analysis of covariance, including site, time in program, baseline value, and eleven other baseline covariates. Shaded values: Adjusted change value is significantly lower ($p < 0.05$) than median site. Bold values: Adjusted change value is significantly higher ($P < 0.05$) than median site.
Percent Change	Change at Follow-up divided by Pre-Entry Mean to get adjusted percent change.

Table 2-17: Fidelity to Assertive Community Treatment Model

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	DACTS self-report by sites; confirmed with other available data.
Human Resources	Average program score on 7 human resources items.
Organizational Boundaries	Average program score on 7 organizational boundaries items.
Services	Average program score on 6 nature of services items.
Sub.Abuse Tx	Average program score on 3 substance abuse treatment items.
Total Score	Total program score: sum of 23 DACTS items.
Avg. Score	Average program score: mean of 23 DACTS items. Original DACTS contains 26 items. Compare VA scores to averages, NOT to totals, for non-VA programs. Shaded values exceed 1 standard deviation below the mean site (undesired). Bold values exceed 1 standard deviation above the mean site (desired).

Table 2-18: VA Hospital Use: 183 Days Before and After Program Entry

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: PTF through 9/30/04.
Total N FY 04	# MHICM veterans as of 9/30/04.
N 183 Days	# MHICM veterans with 183 or more days in program (entered by 3/31/04).
Pre-Entry MH Days/Vet	Mean mental health hospital days per veteran in 183 days before MHICM entry.
Post-Entry MH Days/Vet	Mean mental health hospital days per veteran in 183 days after MHICM entry.
Change MH Days/Vet	Mean change in mental health hospital days (Post- minus pre-MHICM entry).
	Shaded values exceed 1 standard deviation from mean in direction of fewer days/lower %.
	Bold values exceed 1 standard deviation from mean in direction of more days/higher %.
% Change MH Days/Vet	Mean % change in mental health days (Change MH Days/Pre-IDF MH Days).
Inpllt MH Per Diem FY04	Mean national inpatient mental health per diem cost (NMHPPMS): \$1,011 [hidden col.]
Change IP MH Cost/Vet	183-day Inpatient MH reduction per MHICM vet (Inpllt MH Per Diem x Change MH Days).
	Cost change data are unadjusted for inflation and do not fully represent cost reductions achieved for veterans at original MHICM sites.

Table 2-18a: VA Hospital Use: 365 Days Before and After Program Entry**Table 2-18b: VA Hospital Use: 548 Days Before and After Program Entry****Table 2-18c: VA Hospital Use: 730 Days Before and After Program Entry**

The format for these Tables is identical to that for Table 2-18, with increasing Pre- and Post-Entry time frames: a) 365 days; b) 548 days; and c) 730 days. For each table, data are reported only for veterans with sufficient time in the program to allow that Pre-Post comparison. **Program entry is defined by Initial Data Form (IDF) completion date.**

Table 2-19: Brief Psychiatric Rating Scale (Observed symptoms)

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	IDF 34; Follow-up Data form (FDF), Form 37.
	Note: "1" added to each BPRS item to conform with current reporting conventions.
Pre-Entry N	MHICM veterans with entry interview data on this measure.
Pre-Entry Mean	Mean BPRS Total score (sum 18 items) at entry (34: #265-283).
Follow-up Mean	Mean BPRS Total score (sum 18 items) at follow-up (37: #225-243), adjusted for site, time in program, baseline value, and eleven other baseline covariates.
Change at Follow-up	Least squares mean derived from analysis of covariance, including site, time in program, baseline value, and eleven other baseline covariates.
Percent Change	Change to Follow-up divided by Pre-Entry Mean to get adjusted percent change.
	Shaded values: Adjusted change value is significantly higher (p<0.05) than median site.
	Bold values: Adjusted change value is significantly lower (P<0.05) than median site.

Table 2-20: Symptom Severity (Client-reported Brief Symptom Inventory Items)

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	IDF 34; FDF 37 Schizophrenia Outcomes Module & Brief Symptom Inventory items (Note: Replication site variables are scaled differently and not included.)
Pre-Entry N	MHICM veterans with entry interview data on this measure.
Pre-Entry Mean	Mean symptom score at entry (34: #51-80).
Follow-up Mean	Mean symptom score at follow-up (37: #30-59), adjusted for site, time in program, baseline value, and eleven other baseline covariates.
Change at Follow-up	Least squares mean derived from analysis of covariance, including site, time in program, baseline value, and eleven other baseline covariates.
Percent Change	Change to Follow-up divided by Pre-Entry Mean to get adjusted percent change.
	Shaded values: Adjusted change value is significantly higher (p<0.05) than median site.
	Bold values: Adjusted change value is significantly lower (P<0.05) than median site.

Table 2-21: Global Assessment of Functioning (GAF; DSM-IV Axis V)

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	IDF 34; FDF 37.
Pre-Entry N	MHICM veterans with entry interview data on this measure.
Pre-Entry Mean	GAF score at entry (34: #284).
Follow-up Mean	Mean GAF score at follow-up (39: #116) adjusted for site, time in program, baseline value, and 11 baseline covariates.
Change at Follow-up	Least squares mean derived from analysis of covariance, including site, time in program, baseline value, and eleven other baseline covariates.
Percent Change	Change to Follow-up divided by Pre-Entry Mean to get adjusted percent change. Shaded values: Adjusted change value is significantly lower ($p < 0.05$) than median site. Bold values: Adjusted change value is significantly higher ($P < 0.05$) than median site.

Table 2-22: Instrumental Activities of Daily Living (Schizophrenia Outcomes Module items)

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	IDF 34; FDF 37.
Pre-Entry N	MHICM veterans with entry interview data on this measure.
Pre-Entry Mean	Mean IADL score at entry (34: # 114-125).
Follow-up Mean	Mean IADL (37: #77-88) score at follow-up adjusted for site, time in program, baseline value, and eleven other baseline covariates.
Change at Follow-up	Least squares mean derived from analysis of covariance, including site, time in program, baseline value, and eleven other baseline covariates.
Percent Change	Change to Follow-up divided by Pre-Entry Mean to get adjusted percent change. Shaded values: Adjusted change value is significantly lower ($p < 0.05$) than median site. Bold values: Adjusted change value is significantly higher ($P < 0.05$) than median site.

Table 2-23: Quality of Life (Lehman QOLI Delighted-Terrible items)

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	IDF 34; FDF 37.
Pre-Entry N	MHICM veterans with entry interview data on this measure.
Pre-Entry Mean	Mean QOL scores at entry (34: #23,128,136,147,150,240).
Follow-up Mean	Mean QOL scores (37: #14,91,99,110,113,201) adjusted for site, time in program, baseline value, and eleven other baseline covariates.
Change at Follow-up	Least squares mean derived from analysis of covariance, including site, time in program, baseline value, and eleven other baseline covariates.
Percent Change	Change to Follow-up divided by Pre-Entry Mean to get adjusted percent change. Shaded values: Adjusted change value is significantly lower ($p < 0.05$) than median site. Bold values: Adjusted change value is significantly higher ($P < 0.05$) than median site.

Table 2-23a: Housing Independence Index (NEPEC scale)

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	IDF 34; FDF 37: Days in each setting were multiplied by weight for restrictiveness.
Pre-Entry N	MHICM veterans with entry interview data on this measure.
Pre-Entry Sum	Sum of weighted HOU items at entry (34: #138*4, 140*3, 142*2, 144*1, 146*0).
Follow-up Sum	Sum of weighted HOU items at follow-up (37: #101*4, 103*3, 105*2, 107*1, 109*0) adjusted for site, time in program, baseline value, and eleven other baseline covariates.
Change at Follow-up	Least squares mean derived from analysis of covariance, including site, time in program, baseline value, and eleven other baseline covariates.
Percent Change	Change to Follow-up divided by Pre-Entry Mean to get adjusted percent change. Shaded values: Adjusted change value is significantly lower ($p < 0.05$) than median site. Bold values: Adjusted change value is significantly higher ($P < 0.05$) than median site.

Table 2-24: VA Mental Health Services Satisfaction (3 item)

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	IDF 34; FDF 37.
Pre-Entry N	MHICM veterans with entry interview data on VA Mental Health services satisfaction.
Pre-Entry Mean	Sum VA MH Satisfaction score at entry (34: #232,235,239).
Follow-up Mean	Sum VA MH Satisfaction score at follow-up (37: #193,196,200) adjusted for site, time in program, baseline value, and eleven other baseline covariates.
Change at Follow-up	Least squares mean derived from analysis of covariance, including site, time in program, baseline value, and eleven other baseline covariates.
Percent Change	Change to Follow-up divided by Pre-Entry Mean to get adjusted percent change. Shaded values: Adjusted change value is significantly lower ($p<0.05$) than median site. Bold values: Adjusted change value is significantly higher ($P<0.05$) than median site.

Table 2-25: Satisfaction with VA MHICM Services (vs. VA Mental Health Services; single items)

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	FDF 37.
Pre-Entry N	MHICM veterans with entry interview data on VA mental health services satisfaction.
Pre-Entry Mean	Mean VA MH services satisfaction score at entry (34: #228).
Follow-up Mean	Mean MHICM Satisfaction score at follow-up (37: #190) adjusted for site, time in program, baseline value, and eleven other baseline covariates.
Change at Follow-up	Least squares mean derived from analysis of covariance, including site, time in program, baseline value, and eleven other baseline covariates.
Percent Change	Change to Follow-up divided by Pre-Entry Mean to get adjusted percent change. Shaded values: Adjusted change value is significantly lower ($p<0.05$) than median site. Bold values: Adjusted change value is significantly higher ($P<0.05$) than median site.

Table 2-26: MHICM Unit Costs (per Veteran, FTE, Visit)

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: FY 2004 Site-generated annual progress reports, OPC stop codes.
FY04 Total Expenditures	FY 2004 reported total expenditure of MHICM funds.
Total Vets	# MHICM veterans receiving MHICM services in FY 2004 (OPC).
Cost per Veteran	Annual cost per MHICM veteran (FY 04 Total Expenditures divided by Total Vets)
FY04 P/S Expenditures	FY 2004 reported personal service expenditures.
FY04 Filled FTE	MHICM positions reported filled as of September 30, 2004.
Cost per FTE	Annual cost per MHICM FTE (FY 04 P/S Expenditures divided by Total FTE)
Adj. Total Visits/Vet/Yr	Total MHICM stop code visits (per veteran), adjusted for 52 weeks.
Total Visits/Site/Yr	Adjusted Total Visits/Vet/Yr multiplied by Total Vets to get Total Team Visits for FY 2004.
Cost per Visit	Cost per visit (FY 04 Total Expenditures divided by Total Visits per Yr)

Table 2-27: Site Performance on MHICM Critical Monitors

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: Critical monitor outliers identified on tables 2-1 to 2-24.
Structure	# of 5 critical monitors in tables 2-2 to 2-6 in undesired direction.
Client	# of 3 critical monitors in tables 2-7 to 2-11 in undesired direction.
Process	# of 5 critical monitors in tables 2-12 to 2-17 in undesired direction.
Outcome	# of 4 critical monitors in tables 2-18 to 2-25 in undesired direction.
Site Total	Total # of 17 critical monitors in tables 2-2 to 2-25 in undesired direction.

Table 2-28: Outliers for Team Structure Monitors

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: Outliers from Tables 2-5 and 2-6.
FTE Unfilled	Yes = one or more MHICM positions unfilled for 6 or more months (Table 2-5).
Unassigned Medical	N = physician (MD) or nurse-case manager (RN) <u>not</u> assigned to MHICM team (2-6).
Caseload Size	Total # MHICM veterans as of 9/30/03 divided by Clinical FTE as of 9/30/03 (2-6).
Team Size	Clinical FTE as of September 30, 2004 (Monthly FTE/Caseload Report) (2-5).
Total Team Outliers	# Team Structure monitors for which team value is an outlier (range: 0-5).
# Applicable Monitors	# Team Structure monitors that applied to team in FY 2004 (range: 0-5).
% Outliers/Applicable	# team outliers divided by # applicable monitors.

Table 2-29: Outliers for Client Characteristics Monitors

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: Outliers from Tables 2-10 and 2-11.
% Clients GTE 30 Days	% MHICM veterans with 30+ VA hospital days in year before entry (2-10).
% Clients Psychotic Dx	% MHICM veterans with psychotic diagnosis at entry (2-10).
Mean GAF at Entry	Average GAF score at entry for veterans seen by team (2-11).
Total Team Outliers	# Client Characteristics monitors for which team value is an outlier (range: 0-3).
# Applicable Monitors	# Client Characteristics monitors that applied to team in FY 2004 (range: 0-3).
% Outliers/Applicable	# team outliers divided by # applicable monitors.

Table 2-30: Outliers for Clinical Process Monitors

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: Outliers from Tables 2-12, 2-13, 2-14 and 2-15.
Tenure	% veterans discharged as of September 30, 2004 (2-12).
Intensity	% veterans with one hour or more of weekly contact (2-13).
Location	% veterans with 60% or more of contacts in the community (2-13).
Frequency # Adjusted	Mean face-to-face visits, adjusted for each team's amount of time in program, then divided by 52 weeks to get a visits per week value (2-14).
Team provides...Rehab	% veterans receiving rehabilitation services from MHICM team (2-15A).
Total Team Outliers	# Clinical Process monitors for which team value is an outlier (range: 0-5).
# Applicable Monitors	# Clinical Process monitors that applied to team in FY 2004 (range: 0-5).
% Outliers/Applicable	# team outliers divided by # applicable monitors.

Table 2-31: Outliers for Client Outcome Monitors

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: Outliers from Tables 2-18a, 2-19, 2-20 and 2-23.
365 Days % Change	Mean % change in mental health days after 365 days (2-18a).
Reported Symptoms %	Change in BSI at Follow-up (2-20).
Observed Symptoms %	Change in BPRS at Follow-up (2-19).
Quality of Life %	Change in QOL at Follow-up (2-23).

Table 2-32A&B: Outliers for Minimum Standards

	Source: Selected Outliers from Tables 2-5, 2-6, 2-10, 2-12, 2-13, 2-14, and 2-15.
% Clients Psychotic Dx	% vets with psychotic diagnosis at entry (<i>Threshold: 50% or more</i>) (2-10).
% Clients GTE 30 Days	% vets with 30+ psychiatric inpatient days in year pre-entry (<i>50% or more</i>)(2-10).
# Adjusted Face-to-face	Mean adjusted face-to-face visits per week per veteran (<i>1.0 or more</i>)(2-14).
Caseload Size	Ratio of veterans to clinical FTE (mean caseload as of 9/30/01)(<i>7:1 to 15:1</i>) (2-6).
% Clients seen 60%...	% vets for whom 60+% of visits occur in community (<i>50% or more</i>) (2-13).+
Team provides...Rehab	% vets receiving psychiatric rehabilitation/skills training (<i>25% or more</i>) (2-15).
Tenure	% vets discharged from MHICM program in FY 2004 (<i>< 20%</i>) (2-12).
Team Size	# Clinical case managers on team as of 9/30/04 (<i>4.0+ FTEE</i>) (2-5).
Total Outliers	# of 8 minimum standards for which team value was an outlier (range: 0-8).
% Min Stand Outliers	% of 8 minimum standards for which team value was outlier in FY 2004.
% Outliers FY 2001	% of 8 minimum standards for which team value was outlier in FY 2001.
Change % Outliers	Change in team % outliers from FY 2001 to FY 2004.

Table 2-33 Site Outlier Review Summary

	Source: Site completed Outlier Review Forms for indicated outliers.
Site # Outliers	# of critical monitors for which team value was an outlier in undesired direction.
Reason A	# Team responses indicating "Legitimate differences in this site's team that do not conflict with national program goals".
Reason B	# Team responses indicating "Local policies at this site that may conflict with national program goals".
Reason C	# Team responses indicating "Problems in program implementation for which corrective action has been taken".
Reason D	# Team responses indicating "Problems in program implementation for which corrective action has since been planned".
Reason E	# Team responses indicating "Problems in program implementation for which corrective action has not yet been planned".
Sum of Responses	# outliers addressed in Outlier Review.

Appendix E. MHICM Case Management Services, FY 2004 (MHICM Veterans)**Source: VA Outpatient Clinic File (Austin, TX).**

MHICM Community	Visits recorded under DSS Identifier (stop code) #552, MHICM.
# Veterans	Number of veterans with at least one MHICM visit.
# Visits	Total MHICM (stop code 552) visits.
Mn Visits	Mean number of MHICM visits per veteran with at least one visit.
Low Intensity CM Visits	Visits recorded under DSS Identifier #564, General Case Management.
# Veterans	Number of veterans with at least one Low Intensity or General CM visit.
#Visits	Total Low Intensity or General CM (stop code 564) visits.
Mn Visits	Mean number of Low Intensity visits per veteran with at least one visit.
Facility Sum/Mean	Total number of veterans and overall mean of visits across all facilities.
VISN Sum/Mean	Total number of veterans and overall mean of visits across all VISNs.

Appendix F. Non-MHICM Case Management Services, FY 2004 (Non-MHICM Veterans)**Source: VA Outpatient Clinic File (Austin, TX).**

MHICM Community Veterans (N)	Visits recorded under DSS Identifier (stop code) #552, MHICM.
# Visits	Number of veterans with at least one MHICM visit.
Mn Visits	Total MHICM (stop code 552) visits.
General CM Visits Veterans (N)	Mean number of MHICM visits per veteran with at least one visit.
#Visits	Visits recorded under DSS Identifier #564, General Case Management.
Mn Visits	Number of veterans with at least one General/Low Intensity CM visit.
Facility Sum/Mean	Total General/Low Intensity (stop code 564) visits.
VISN Sum/Mean	Mean number of Low Intensity visits per veteran with at least one visit.
	Total number of veterans and overall mean of visits across all facilities.
	Total number of veterans and overall mean of visits across all VISNs.

Appendix G. MHICM Complex VERA Veterans, FY 2004**Source: Allocation Resource Center; NEPEC Monitoring Files.**

MHICM Vets	Veterans registered in MHICM program during FY 2004.
Complex VERA Vets #	Veterans identified by ARC with 41 or more MHICM stop Code 552 Visits in FY 04. Note: Additional veterans may have previously qualified for complex class status in other patient classes (e.g. chronic mental illness) based on prior VA service use or retention criteria.
Complex VERA Vets %	Percentage of MHICM registered veterans identified as MHICM Complex VERA Class.

Appendix H. MHICM Program Monitor Trends, FY 1997-2004

Source: MHICM Performance Monitoring Reports, FY 1997-2004.

FY 1997 - FY 2004 values are presented for select MHICM performance monitors, by monitoring domain, along with the percent change in values between 1997-2004.

Team Structure

Teams	Total MHICM teams in FY 2004 (71 teams included in FY 2004 Report).
Clients	Total veteran clients included in FY 2004 report.
Expenditure	Total program expenditures for 71 MHICM teams in FY 2004 report.
Assigned FTEE	Total FTE assigned to 71 MHICM teams in the FY 2004 report.
Filled FTEE	Total filled FTEE for 71 MHICM teams in FY 2004 report.
% Filled	Filled FTEE divided by assigned FTE.
Staff detailed away	% of filled FTE detailed part-time to other services.
Cost/Client	Unit cost per MHICM client
Client/Staff ratio	Mean client to staff ratio (caseload size). MHICM range: 7:1 to 15:1.

Client Characteristics

Age	Mean client age at entry.
Minority race / ethnicity	Percent minority race / ethnicity.
Mean hospital days yr pre	Mean hospital days per veteran in year preceding entry.
% 30+ hospital days yr pre	Percent of clients meeting minimum hospital days criterion at entry: 30+ days in prior year.
2+ yrs hospital lifetime	Percent of clients with 2 or more years of total lifetime psychiatric hospitalization.
Psychotic diagnosis	Percent clients with a primary psychiatric diagnosis with psychosis at entry.
Substance use diagnosis	Percent of clients with co-occurring substance use diagnosis at entry.
Paid employment (3yrs)	Percent of clients reporting paid employment in the three years preceding entry.
Public support income	Percent of clients receiving public support income from VA or social security at entry.

MHICM Services

Contacted weekly	Percent of clients contacted weekly or more frequently.
Contacts/week	Face-to-face contacts per week adjusted for portion of year in program.
60%+ visits community	Percent of clients with 60% or more of contacts occurring in the community.
Discharged	Percent of MHICM clients discharged during FY 2004.
Client-rated Alliance	Therapeutic alliance score reported by MHICM clients at follow-up
Team ACT Fidelity Score	Mean ACT fidelity score for MHICM teams overall.

Client Outcome (Follow-up)

Observed symptoms	Percent change in BPRS score from entry to follow-up.
Reported symptoms	Percent change in BSI score from entry to follow-up.
Quality of Life reported	Percent change in Quality of Life score from entry to follow-up.
Satisfaction MHICM (1-5)	Percent change in Client Satisfaction with MHICM at follow-up.
Change Inpt days (6mos.)	Change in psychiatric hospital days during first 6 months.
% Change Inpt days (6mo)	Percent change in psychiatric hospital days during first 6 months.

Acronyms

ACCESS	MICROSOFT RELATIONAL DATABASE SOFTWARE
ACT	ASSERTIVE COMMUNITY TREATMENT (PROGRAM MODEL)
ADJ	ADJUSTED SCORE
AVG/MN	AVERAGE
BPRS	BRIEF PSYCHIATRIC RATING SCALE
BSI	BRIEF SYMPTOM INVENTORY
CM	CASE MANAGEMENT OR CASE MANAGER
CPR	CLINICAL PROGRESS REPORT FORM (NEPEC MONITORING FORM 39)
DSS	DECISION SUPPORT SYSTEM (VHA FISCAL SOFTWARE)
DX	DIAGNOSIS
FDF	FOLLOW-UP DATA FORM (NEPEC MONITORING FORM 37)
FTE	FULL TIME EQUIVALENT POSITION
FY	FISCAL YEAR
GAF	GLOBAL ASSESSMENT OF FUNCTIONING SCORE
GM+S	GENERAL MEDICINE AND SURGERY FACILITY
GTE	GREATER THAN OR EQUAL TO
HOU1	HOUSING INDEPENDENCE INDEX
IADL	INSTRUMENTAL ACTIVITIES OF DAILY LIVING
IDF	INITIAL DATA FORM (NEPEC MONITORING FORM 34)
IDF DATE	INITIAL DATA FORM DATE
IP	INPATIENT
MAX	MAXIMUM
MD	PHYSICIAN, PSYCHIATRIST
MH	MENTAL HEALTH
MIN	MINIMUM
NEPEC	NORTHEAST PROGRAM EVALUATION CENTER (WEST HAVEN, CONNECTICUT)
NP	FORMER NEUROPSYCHIATRIC FACILITY
NSC	NON-SERVICE-CONNECTED
OPC	OUTPATIENT CLINIC FILE (VHA OUTPATIENT AUTOMATED DATA, AUSTIN TX)
PTF	PATIENT TREATMENT FILE (VHA INPATIENT AUTOMATED DATA, AUSTIN TX)
PRE-ENTRY	PERIOD BEFORE ADMISSION TO MHICM
QOL	QUALITY OF LIFE SCALE
RN	NURSE
SAS	STATISTICAL ANALYSIS SYSTEM SOFTWARE
SC	SERVICE-CONNECTED
SSI	SOCIAL SECURITY SUPPLEMENTAL INCOME
SSDI	SOCIAL SECURITY DISABILITY INCOME
TX	TREATMENT
YR	YEAR
VERA	VETERANS EQUITABLE RESOURCE ALLOCATION (VA BUDGETING STRUCTURE)
VHA	VETERANS HEALTH ADMINISTRATION
VISN	VETERANS INTEGRATED SERVICE NETWORK (MULTI-SITE HEALTH SYSTEM)

Appendix E
MHICM Case Management Services, FY 2004 (Registered MHICM Veterans*)

SITE			MHICM Visits (Stop Code 552 Visits)			Low Intensity CM Visits (Stop Code 564 Visits)		
VISN CODE	SITE NAME/VISN		#Veterans	#Visits	MnVisits	#Veterans	#Visits	MnVisits
1 518	BEDFORD		128	12,142	94.9	0	0	0.0
1 523A5	BROCKTON		79	3,011	38.1	0	0	0.0
1 402	TOGUS		27	1,322	49.0	0	0	0.0
1 689	WEST HAVEN		60	4,328	72.1	0	0	0.0
	VISN 1		294	20,803	63.5	0	0	0.0
2 528A8	ALBANY		48	4,213	87.8	0	0	0.0
2 528	BUFFALO		81	3,121	38.5	0	0	0.0
2 528A5	CANANDAIGUA		93	7,462	80.2	0	0	0.0
2 528A7	SYRACUSE		50	1,726	34.5	0	0	0.0
	VISN 2		272	16,522	60.3	0	0	0.0
3 630A4	BROOKLYN		55	1,594	29.0	0	0	0.0
3 620	MONTROSE		96	5,126	53.4	2	6	3.0
3 561	NEW JERSEY		85	3,564	41.9	8	145	18.1
3 632	NORTHPORT		100	5,452	54.5	2	19	9.5
	VISN 3		336	15,736	44.7	12	170	7.7
4 542	COATESVILLE		96	4,719	49.2	47	277	5.9
4 646A5	PITTSBURGH		132	4,642	35.2	0	0	0.0
	VISN 4		228	9,361	42.2	47	277	2.9
5 613	MARTINSBURG		31	961	31.0	0	0	0.0
5 512A5	PERRY POINT		88	3,830	43.5	0	0	0.0
	VISN 5		119	4,791	37.3	0	0	0.0
6 565	FAYETTEVILLE		26	1,761	67.7	0	0	0.0
6 590	HAMPTON		57	3,755	65.9	1	1	1.0
6 658	SALEM		40	1,555	38.9	4	9	2.3
6 659	SALISBURY		35	1,877	53.6	13	84	6.5
	VISN 6		158	8,948	56.5	18	94	2.4
7 508	ATLANTA		56	4,083	72.9	0	0	0.0
7 509	AUGUSTA		69	3,533	52.1	0	0	0.0
7 521	BIRMINGHAM		25	1,937	77.5	0	0	0.0
7 679	TUSCALOOSA		67	4,900	73.1	0	0	0.0
7 619A4	TUSKEGEE		50	3,123	62.5	0	0	0.0
	VISN 7		267	17,576	67.6	0	0	0.0
8 573	GAINESVILLE		60	3,894	64.9	0	0	0.0
8 546	MIAMI		52	3,702	71.2	0	0	0.0
8 673	TAMPA		52	2,568	49.4	0	0	0.0
	VISN 8		164	10,164	61.8	0	0	0.0
10 538	CHILLICOTHE		70	3,829	54.7	0	0	0.0
10 539	CINCINNATI		114	4,999	43.9	0	0	0.0
10 541	CLEVELAND		166	9,868	59.5	10	21	2.1
10 757	COLUMBUS		27	1,030	38.2	0	0	0.0
10 552	DAYTON		107	4,471	41.8	0	0	0.0
10 541B2	YOUNGSTOWN		44	2,905	66.0	0	0	0.0
	VISN 10		528	27,102	50.7	10	21	0.4
11 506	ANN ARBOR HCS		53	3,865	72.9	0	0	0.0
11 515	BATTLE CREEK		70	3,722	53.2	34	58	1.7
11 553	DETROIT VAMC		94	3,005	32.0	1	2	2.0
11 610	NORTHERN INDIANA		81	5,468	67.5	1	7	7.0
	VISN 11		298	16,060	56.4	36	67	2.7
12 537	CHICAGO WEST SIDE		63	4,034	64.0	0	0	0.0

SITE			MHICM Visits (Stop Code 552 Visits)			Low Intensity CM Visits (Stop Code 564 Visits)		
VISN CODE	SITE NAME/VISN		#Veterans	#Visits	MnVisits	#Veterans	#Visits	MnVisits
12 607	MADISON		48	6,420	133.8	0	0	0.0
12 695	MILWAUKEE		31	2,013	64.9	0	0	0.0
12 556	NORTH CHICAGO		117	12,277	104.9	0	0	0.0
12 676	TOMAH,WI		46	5,171	112.4	0	0	0.0
	VISN 12		305	29,915	96.0	0	0	0.0
15 657A7	ST.LOUIS,MO		52	2,736	52.6	0	0	0.0
15 677	TOPEKA		108	12,451	115.3	0	0	0.0
	VISN 15		160	15,187	84.0	0	0	0.0
16 520	GULF COAST		57	2,650	46.5	3	3	1.0
16 580	HOUSTON		62	2,720	43.9	0	0	0.0
16 598	LITTLE ROCK		48	3,492	72.8	42	268	6.4
16 629	NEW ORLEANS		57	1,996	35.0	0	0	0.0
	VISN 16		224	10,858	49.5	45	271	1.8
17 549	DALLAS		71	5,185	73.0	0	0	0.0
17 685	WACO		47	3,530	75.1	0	0	0.0
	VISN 17		118	8,715	74.1	0	0	0.0
18 501	ALBUQUERQUE		62	4,867	78.5	0	0	0.0
18 644	PHOENIX		80	2,416	30.2	0	0	0.0
	VISN 18		142	7,283	54.4	0	0	0.0
19 554	DENVER		74	3,697	50.0	0	0	0.0
19 575	GRAND JUNCTION		48	2,695	56.2	0	0	0.0
19 660	SALT LAKE CITY		54	2,518	46.6	4	4	1.0
19 666	SHERIDAN		17	643	37.8	0	0	0.0
19 567	SOUTHERN COLORADO		90	4,711	52.3	0	0	0.0
	VISN19		283	14,264	48.6	4	4	0.2
20 663A4	AMERICAN LAKE		49	2,435	49.7	1	1	1.0
20 531	BOISE		40	963	24.1	0	0	0.0
20 648	PORTLAND		75	4,581	61.1	8	20	2.5
20 663	SEATTLE		56	2,774	49.5	1	20	20.0
	VISN 20		220	10,753	46.1	10	41	5.9
21 640	PALO ALTO		45	1,838	40.8	0	0	0.0
21 662	SAN FRANCISCO		45	2,421	53.8	0	0	0.0
	VISN 21		90	4,259	47.3	0	0	0.0
22 691	GREATER LOS ANGELES		48	1021	21.3	0	0	0.0
22 664	SAN DIEGO		47	2379	50.6	0	0	0.0
	VISN 22		95	3,400	35.9	0	0	0.0
23 636A8	IOWA CITY,IA		42	1,683	40.1	0	0	0.0
23 636A7	KNOXVILLE		89	4,432	49.8	0	0	0.0
23 618	MINNEAPOLIS		68	3,201	47.1	1	3	3.0
23 636	OMAHA,NE		39	2,239	57.4	0	0	0.0
23 656	ST.CLOUD		38	1,470	38.7	3	18	6.0
	VISN 23		276	13,025	46.6	4	21	1.8
	Facility Sum		4,577	264,722	57.8	186	966	5.2
	VISN Mean		229	13,236	56.2	9	48	1.3
	Standard Deviation		101.8	6839.8	14.9	15.0	86.1	2.1
	Coefficient of Variation		0.4	0.5	0.3	1.6	1.8	1.6

* MHICM teams submitted Initial Data Forms and Follow-up monitoring data for these veterans to NEPEC.

Appendix F
Non-MHICM Case Management Services, FY 2004
(Non-MHICM Veterans at MHICM and Non-MHICM Sites~)

SITE			MHICM Visits (Stop Code 552)			General CM Visits (Stop Code 564)		
VISN	CODE	SITE NAME	#Veterans	#Visits	MnVisits	#Veterans	#Visits	MnVisits
1	402	TOGUS*	34	712	20.9	0	0	0.0
1	518	BEDFORD*	92	1,718	18.7	0	0	0.0
1	523A5	BROCKTON VAMC*	20	75	3.8	0	0	0.0
1	523GB	WORCESTER CBOC MA	3	3	1.0	0	0	0.0
1	689	WEST HAVEN*	1	1	1.0	0	0	0.0
		VISN 1	150	2,509	16.7	0	0	0.0
2	528	UPSTATE N.Y. HCS BUFFALO*	51	325	6.4	0	0	0.0
2	528A5	CANANDIAGUA DIVISION*	71	3,438	48.4	0	0	0.0
2	528A7	HCS UPSTATE NY V2 SYRACUSE*	21	160	7.6	0	0	0.0
2	528A8	HCS UPSTATE NY V2 ALBANY*	39	131	3.4	0	0	0.0
		VISN 2	182	4,054	22.3	0	0	0.0
3	526	BRONX#	200	1,561	7.8	0	0	0.0
3	561A4	LYONS*	13	234	18.0	2	3	1.5
3	561BY	NEWARK-SOC	6	9	1.5	40	691	17.3
3	620	MONTROSE VA HUDSON HCS NY*	16	197	12.3	73	477	6.5
3	620A4	CASTLE PNT VA HUDSON HCS NY	2	7	3.5	0	0	0.0
3	620GA	NEW CITY (ROCKLAND) CBOC	0	0	0.0	86	262	3.1
3	630GC	BROOKLYN CBOC	19	215	11.3	0	0	0.0
3	632	NORTHPORT*	40	465	11.6	2	61	30.5
		VISN 3	296	2,688	9.1	203	1,494	7.4
4	540	CLARKSBURG	14	15	1.1	0	0	0.0
4	542	COATESVILLE*	51	315	6.2	171	2,197	12.9
4	595	LEBANON	9	266	29.6	17	201	11.8
4	642	PHILADELPHIA (OLD)	25	659	26.4	0	0	0.0
4	646A5	PITTSBURGH-HIGHLAND DR*	13	222	17.1	0	0	0.0
4	693B4	ALLENTOWN-SOC	5	11	2.2	0	0	0.0
4	693	WILKES BARRE	43	282	6.6	0	0	0.0
		VISN 4	160	1,770	11.1	188	2,398	12.8
5	512	BALTIMORE*	37	918	24.8	0	0	0.0
5	512A5	PERRY POINT*	53	290	5.5	0	0	0.0
5	613	MARTINSBURG	12	112	9.3	0	0	0.0
5	688	WASHINGTON DC*	129	1,912	14.8	0	0	0.0
		VISN 5	231	3,232	14.0	0	0	0.0
6	558	DURHAM	0	0	0.0	33	362	11.0
6	565	FAYETTEVILLE NC*	12	99	8.3	0	0	0.0
6	590	HAMPTON*	40	317	7.9	0	0	0.0
6	637	ASHEVILLE-OTTEEN	0	0	0.0	57	122	2.1
6	658	SALEM*	21	200	9.5	202	422	2.1
6	659	SALISBURY*	12	114	9.5	110	981	8.9
6	659GA	CHARLOTTE CBOC	0	0	0.0	138	544	3.9
		VISN 6	85	730	8.6	540	2,431	4.5
7	508	ATLANTA*	20	30	1.5	0	0	0.0
7	509A0	LENWOOD	26	108	4.2	0	0	0.0
7	521	BIRMINGHAM^	10	42	4.2	0	0	0.0
7	534	CHARLESTON	27	1,179	43.7	0	0	0.0
7	544	COLUMBIA SC^	76	2,108	27.7	0	0	0.0
7	557	DUBLIN	1	5	5.0	0	0	0.0
7	619	MONTGOMERY	5	5	1.0	0	0	0.0
7	619A4	TUSKEGEE*	50	747	14.9	0	0	0.0
7	679	TUSCALOOSA*	58	413	7.1	0	0	0.0
		VISN 7	273	4,637	17.0	0	0	0.0
8	546	MIAMI*	35	133	3.8	0	0	0.0
8	548	W PALM BEACH^	7	182	26.0	2	2	1.0
8	573	N FL/S GA HCS*	23	117	5.1	0	0	0.0
8	672	SAN JUAN PR	0	0	0.0	43	50	1.2

Appendix F
Non-MHICM Case Management Services, FY 2004
(Non-MHICM Veterans at MHICM and Non-MHICM Sites~)

SITE			MHICM Visits (Stop Code 552)			General CM Visits (Stop Code 564)		
VISN	CODE	SITE NAME	#Veterans	#Visits	MnVisits	#Veterans	#Visits	MnVisits
8	673	TAMPA*	23	229	10.0	0	0	0.0
8	673BY	ORLANDO-SOC	8	31	3.9	0	0	0.0
		VISN 8	96	692	7.2	45	52	1.2
9	621	MOUNTAIN HOME*	188	2,100	11.2	0	0	0.0
		VISN 9	188	2,100	11.2	0	0	0.0
10	538	CHILLICOTHE*	12	159	13.3	15	402	26.8
10	539	CINCINNATI*	52	416	8.0	0	0	0.0
10	541A0	CLEVELAND-BRECKSVILLE*	42	578	13.8	12	30	2.5
10	541GB	LORAIN CBOC^	4	10	2.5	0	0	0.0
10	541GD	MANSFIELD CBOC^	22	763	34.7	48	850	17.7
10	541GF	PINESVILLE CBOC PH	4	6	1.5	0	0	0.0
10	541GI	WARREN CBOC CLEVELAND OH^	15	128	8.5	0	0	0.0
10	552	DAYTON*	16	115	7.2	0	0	0.0
10	552GA	MIDDLETOWN CBOC	1	2	2.0	0	0	0.0
10	552GB	LIMA CBOC OH	3	5	1.7	0	0	0.0
10	552GC	RICHMOND CBOC IN	5	47	9.4	0	0	0.0
10	552GD	SPRINGFIELD CBOC OH	8	32	4.0	0	0	0.0
10	757	COLUMBUS-IOC	9	65	7.2	0	0	0.0
10	757GB	GROVE CITY CBOC OH	20	171	8.6	0	0	0.0
		VISN 10	213	2,497	11.7	75	1,282	17.1
11	506	ANN ARBOR HCS*	4	253	63.3	0	0	0.0
11	515	BATTLE CREEK*	47	382	8.1	78	259	3.3
11	550	VA ILLIANA HCS DANVILLE IL	33	1,190	36.1	31	2,514	81.1
11	550BY	PEORIA-SOC	0	0	0.0	1	3	3.0
11	553	DETROIT VAMC*	9	91	10.1	0	0	0.0
11	610	NORTHERN INDIANA HCS*	15	419	27.9	10	324	32.4
11	610A4	NORTHERN IN HCS	0	0	0.0	46	1,445	31.4
		VISN 11	108	2,335	21.6	166	4,545	27.4
12	537	VA CHICAGO HCS*	31	571	18.4	0	0	0.0
12	556	NORTH CHICAGO*	33	390	11.8	0	0	0.0
12	556GD	KENOSHA CBOC WI	2	2	1.0	0	0	0.0
12	578	HINES	3	5	1.7	104	4,655	44.8
12	607	MADISON*	10	128	12.8	0	0	0.0
12	676	TOMAH*	17	272	16.0	0	0	0.0
12	695	MILWAUKEE*	3	7	2.3	0	0	0.0
		VISN 12	99	1,375	13.9	0	0	0.0
15	589A5	COLMERY-ONEIL VAMC HCS KS*	53	1,464	27.6	26	87	3.4
15	657A0	ST LOUIS-Jeff Bks.	36	200	5.6	0	0	0.0
		VISN 15	89	1,664	18.7	26	87	3.3
16	520	GULF COAST HCS	0	0	0.0	4	4	1.0
16	520A0	GULFPORT*	32	217	6.8	7	9	1.3
16	580	HOUSTON*	16	223	13.9	0	0	0.0
16	586	JACKSON	0	0	0.0	72	267	3.7
16	598A0	N. LITTLE ROCK*	43	145	3.4	641	4,825	7.5
16	629	NEW ORLEANS*	5	114	22.8	0	0	0.0
		VISN 16	96	699	7.3	724	5,105	7.1
17	549	DALLAS*	23	160	7.0	0	0	0.0
17	671	SAN ANTONIO^	27	1,582	58.6	0	0	0.0
17	674A4	WACO*	52	771	14.8	0	0	0.0
		VISN 17	102	2,513	25	0	0	0.0
18	501	NEW MEXICO HCS*	16	25	1.6	0	0	0.0
18	644	PHOENIX*	47	481	10.2	55	294	5.4
		VISN 18	63	506	8.0	55	294	5.3
19	442	CHEYENNE	41	689	16.8	0	0	0.0
19	554	DENVER*	33	779	23.6	8	55	6.9

Appendix F
Non-MHICM Case Management Services, FY 2004
(Non-MHICM Veterans at MHICM and Non-MHICM Sites~)

SITE			MHICM Visits (Stop Code 552)			General CM Visits (Stop Code 564)		
VISN	CODE	SITE NAME	#Veterans	#Visits	MnVisits	#Veterans	#Visits	MnVisits
19	554GE	COLORADO SPGS CBOC CO	11	113	10.3	0	0	0.0
19	554GG	LA JUNTA CBOC CO	6	43	7.2	0	0	0.0
19	575	GRAND JUNCTION*	18	164	9.1	0	0	0.0
19	660	SALT LAKE CITY HTHCARE*	26	246	9.5	4	6	1.5
19	666	SHERIDAN^	19	89	4.7	0	0	0.0
		VISN 19	154	2,123	13.8	12	61	5.1
20	531	BOISE*	11	19	1.7	0	0	0.0
20	648	PORTLAND*	39	717	18.4	15	245	16.3
20	653	ROSEBURG	65	765	11.8	0	0	0.0
20	653BY	EUGENE-SOC	7	78	11.1	0	0	0.0
20	663	PUGET SOUND HCS*	32	107	3.3	1	2	2.0
20	663A4	AMERICAN LAKE*	9	182	20.2	0	0	0.0
20	668	SPOKANE WA#	0	0	0.0	98	2,355	24.0
		VISN 20	163	1,868	11.5	114	2,602	22.8
21	640A0	PALO ALTO-MENLO PK	9	15	1.7	0	0	0.0
21	640BY	SAN JOSE	13	19	1.5	0	0	0.0
		VISN 21	22	34	1.5	0	0	0.0
22	593	VA SOUTHERN NEVADA HCS	0	0	0.0	66	639	9.7
22	600	VA LONG BEACH HCS CA	24	564	23.5	1	1	1.0
22	600GC	LONG BEACH CBOC	0	0	0.0	114	130	1.1
22	664	VA SAN DIEGO HCS CA^	32	87	2.7	0	0	0.0
22	691	GREATER LA HCS*	43	103	2.4	1	1	1.0
		VISN 22	99	754	7.6	182	771	4.2
23	437	FARGO	0	0	0.0	117	736	6.3
23	438	SIOUX FALLS	0	0	0.0	113	697	6.2
23	618	MINNEAPOLIS*	5	21	4.2	0	0	0.0
23	636	VA NEB-WESTERN IA HCS*	5	25	5.0	0	0	0.0
23	636A6	VA CPHN DES MOINES IA*	7	132	18.9	0	0	0.0
23	636A7	VA CPHN KNOXVILLE IA*	26	271	10.4	0	0	0.0
23	636A8	VA CPHN IOWA CITY IA*	11	153	13.9	0	0	0.0
23	656	ST CLOUD*	7	107	15.3	21	327	15.6
		VISN 23	61	709	11.6	251	1,760	7.0
		ALL SUM/MEAN	2,930	39,489	13.5	2,581	22,882	8.9
		VISN Mean	140	1,880	12.8	123	1,090	6.0
		Standard Deviation	69.8	1168.6	5.6	185.6	1510.0	7.9
		Coefficient of Variation	0.5	0.6	0.4	1.5	1.4	1.3

~ Non-MHICM veterans were identified through VHA Automated databases in Austin, Texas.

* MHICM team operational during in FY 2004. # MHICM team not operational in FY 2004.

^ MHICM team in development during FY 2004.

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Appendix G **MHICM Complex VERA Veterans, FY 2004**

This table presents numbers and proportions of veterans added to the Complex Care VERA reimbursement class due to participation in MHICM. To attain this reimbursement status, veterans must be registered in MHICM and receive 41 or more MHICM clinic stops (visits) during the fiscal year. These criteria are monitored by VHA's Allocation Resource Center (ARC) and the Northeast Program Evaluation Center (NEPEC). For FY 2004, VERA reimbursement for a veteran in the VERA MHICM Complex Care Patient Class was set at \$35,957 per year.

VISN	Site Code	Site Name	MHICM Veterans FY 2004 #	MHICM Complex^ VERA Veterans #	MHICM Complex VERA Veterans %	CMI Complex~ VERA Veterans #	CMI Complex VERA Veterans %	Total Complex VERA Veterans
1	518	Bedford	130	90	69.2%	29	22.3%	91.5%
1	523A5	Brockton	79	34	43.0%	38	48.1%	91.1%
1	402	Togus	27	19	70.4%	3	11.1%	81.5%
1	689	West Haven	62	46	74.2%	10	16.1%	90.3%
		VISN 1	298	189	63.4%	80	26.8%	90.3%
2	528A8	Albany	49	30	61.2%	11	22.4%	83.7%
2	528	Buffalo	83	39	47.0%	22	26.5%	73.5%
2	528A5	Canandaigua	101	66	65.3%	27	26.7%	92.1%
2	528A7	Syracuse	53	13	24.5%	23	43.4%	67.9%
		VISN 2	286	148	51.7%	83	29.0%	80.8%
3	630A4	Brooklyn	58	16	27.6%	29	50.0%	77.6%
3	620	Montrose	102	75	73.5%	20	19.6%	93.1%
3	561A4	New Jersey	89	38	42.7%	35	39.3%	82.0%
3	632	Northport	103	56	54.4%	39	37.9%	92.2%
		VISN 3	352	185	52.6%	123	34.9%	87.5%
4	542	Coatesville	101	49	48.5%	35	34.7%	83.2%
4	646A5	Pittsburgh	136	45	33.1%	73	53.7%	86.8%
		VISN 4	237	94	39.7%	108	45.6%	85.2%
5	512	Martinsburg	33	9	27.3%	11	33.3%	60.6%
5	512A5	Perry Point	91	41	45.1%	44	48.4%	93.4%
		VISN 5	124	50	40.3%	55	44.4%	84.7%
6	590	Fayetteville, NC	27	23	85.2%	1	3.7%	88.9%
6	658	Hampton	59	35	59.3%	16	27.1%	86.4%
		Salem	44	17	38.6%	17	38.6%	77.3%
6	659	Salisbury	38	22	57.9%	11	28.9%	86.8%
		VISN 6	168	97	57.7%	45	26.8%	84.5%
7	508	Atlanta	61	45	73.8%	10	16.4%	90.2%
7	509	Augusta	71	40	56.3%	26	36.6%	93.0%
		Birmingham	25	18	72.0%	6	24.0%	96.0%
7	679	Tuscaloosa	69	49	71.0%	18	26.1%	97.1%
7	619A4	Tuskegee	52	37	71.2%	10	19.2%	90.4%
		VISN 7	278	189	68.0%	70	25.2%	93.2%
8	573	Gainesville	62	44	71.0%	15	24.2%	95.2%
		Miami	53	43	81.1%	7	13.2%	94.3%
8	546	Tampa	52	27	51.9%	8	15.4%	67.3%
		VISN 8	167	114	68.3%	30	18.0%	86.2%
10	538	Chillicothe	73	51	69.9%	5	6.8%	76.7%
10	539	Cincinnati	116	91	78.4%	10	8.6%	87.1%
10	541	Cleveland	169	99	58.6%	34	20.1%	78.7%
10	757	Columbus	27	9	33.3%	11	40.7%	74.1%
10	552	Dayton	110	69	62.7%	12	10.9%	73.6%
10	541B2	Youngstown	45	25	55.6%	9	20.0%	75.6%
		VISN 10	540	344	63.7%	81	15.0%	78.7%
11	506	Ann Arbor	54	25	46.3%	19	35.2%	81.5%
11	515	Battle Creek	72	50	69.4%	13	18.1%	87.5%
11	553	Detroit	94	26	27.7%	54	57.4%	85.1%
11	610	Northern Indiana	82	51	62.2%	23	28.0%	90.2%
		VISN 11	302	152	50.3%	109	36.1%	86.4%

VISN	Site Code	Site Name	MHICM Veterans FY 2004 #	MHICM Complex^ VERA Veterans #	MHICM Complex VERA Veterans %	CMI Complex~ VERA Veterans #	CMI Complex VERA Veterans %	Total Complex VERA Veterans
12	537	Chicago West Side	70	44	62.9%	17	24.3%	87.1%
12	607	Madison	49	39	79.6%	3	6.1%	85.7%
12	695	Milwaukee	33	24	72.7%	8	24.2%	97.0%
12	556	North Chicago	118	90	76.3%	19	16.1%	92.4%
12	676	Tomah	48	30	62.5%	6	12.5%	75.0%
		VISN 12	318	227	71.4%	53	16.7%	88.1%
15	657A0	ST. Louis	54	28	51.9%	12	22.2%	74.1%
15	589A5	Topeka	112	79	70.5%	23	20.5%	91.1%
		VISN 15	166	107	64.5%	35	21.1%	85.5%
16	520	Gulf Coast	61	18	29.5%	36	59.0%	88.5%
16	580	Houston	64	48	75.0%	10	15.6%	90.6%
16	598	Little Rock	49	37	75.5%	9	18.4%	93.9%
16	629	New Orleans	58	25	43.1%	19	32.8%	75.9%
		VISN 16	232	128	55.2%	74	31.9%	87.1%
17	549	Dallas	73	56	76.7%	8	11.0%	87.7%
17	685	Waco	65	36	55.4%	18	27.7%	83.1%
		VISN 17	138	92	66.7%	26	18.8%	85.5%
18	501	Albuquerque	64	43	67.2%	13	20.3%	87.5%
18	644	Phoenix	84	25	29.8%	22	26.2%	56.0%
		VISN 18	148	68	45.9%	35	23.6%	69.6%
19	554	Denver	74	48	64.9%	22	29.7%	94.6%
19	575	Grand Junction	48	29	60.4%	11	22.9%	83.3%
19	660	Salt Lake City	56	27	48.2%	20	35.7%	83.9%
19	666	Sheridan	18	6	33.3%	9	50.0%	83.3%
19	567	Southern Colorado	97	62	63.9%	17	17.5%	81.4%
		VISN 19	293	172	58.7%	79	27.0%	85.7%
20	663A4	American Lake	51	36	70.6%	15	29.4%	100.0%
20	531	Boise	42	2	4.8%	23	54.8%	59.5%
20	648	Portland	78	46	59.0%	24	30.8%	89.7%
20	663	Seattle	58	24	41.4%	23	39.7%	81.0%
		VISN 20	229	108	47.2%	85	37.1%	84.3%
21	640	Palo Alto	45	27	60.0%	13	28.9%	88.9%
21	662	San Francisco	48	33	68.8%	10	20.8%	89.6%
		VISN 21	93	60	64.5%	23	24.7%	89.2%
22	691	Greater Los Angeles	51	4	7.8%	37	72.5%	80.4%
		San Diego	48	24	50.0%	14	29.2%	79.2%
		VISN 22	99	28	28.3%	51	51.5%	79.8%
23	636A8	Iowa City	50	23	46.0%	13	26.0%	72.0%
23	636A7	Knoxville	90	62	68.9%	16	17.8%	86.7%
23	618	Minneapolis	72	40	55.6%	24	33.3%	88.9%
23	636	Omaha	42	24	57.1%	8	19.0%	76.2%
23	656	St. Cloud	39	14	35.9%	20	51.3%	87.2%
		VISN 23	293	163	55.6%	81	27.6%	83.3%
		ALL SUM/MEAN	4,761	2,715	57.0%	1,326	27.9%	84.9%
		VISN Mean	227	129	55.7%	63	29.1%	84.8%
		Standard Deviation	103.7	70.3	11.0%	28.3	9.7%	4.8%
		Coefficient of Variation	0.5	0.5	0.2	0.4	0.3	0.1

^MHICM veterans with 41 or more MHICM visits (Clinic Stop 552) during FY 2004.

~MHICM veterans assigned to Chronic Mental Illness (CMI) Patient Class based on diagnosis and prior service use.

Source: Allocation Resource Center; NEPEC Monitoring files.

Appendix H

MHICM Program Monitor Trends, FY 1997-2004

<u>Team Structure</u>	1997	2001	2002	2003	2004	% change 2004-1997
Teams*	40	55	72	74	78	95%
Clients^	2,021	3,189	3,566	4,108	4,761	136%
Expenditures	\$12.7M	\$18.4M	\$20.0M	\$26.7M	\$33.8M	166%
Assigned FTEE	246	289	315	393	453	84%
Filled FTEE	221	251	283	356	415	88%
% Filled	90%	87%	90%	91%	92%	2%
Teams with 4.0 Clinical FTE	53%	46%	46%	54%	51%	-3%
Staff detailed away PT (sites)	8%	25%	21%	30%	16%	100%
Cost/Client	\$6,049	\$5,777	\$5,607	\$6,509	\$7,105	17%
Client/Staff ratio	12.3	13.2	12.9	12.3	12.5	2%

<u>Client Characteristics (Entry)</u>	1997	2001	2002	2003	2004	% change 2004-1997
Age	49.2	49.8	49.9	50.2	50.4	2%
Minority race / ethnicity	29.1%	32.1%	32.4%	33.9%	33.2%	14%
Mean hospital days in year pre	135.4	99.9	92.3	87.9	79.6	-41%
30+ Hospital days in year pre	91.3%	78.6%	76.9%	76.6%	75.1%	-18%
2+ yrs Hospitalized in lifetime	57.9%	56.9%	48.2%	46.8%	43.6%	-25%
Psychotic diagnosis	87.0%	90.7%	90.7%	90.2%	88.9%	2%
Substance use diagnosis	25%	20%	20%	20.8%	20.9%	-16%
Paid employment (3yrs pre)	12.5%	11.3	11.5%	11.4%	12.5%	0%
Public support income	90.6%	94.1%	94.8%	94.2%	94.1%	4%

<u>MHICM Services</u>	1997	2001	2002	2003	2004	% change 2004-1997
Contacted weekly	85%	81%	87%	87%	88%	4%
Contacts/week	1.6	1.3	1.4	1.4	1.3	-19%
60% + contacts in community	78%	84%	88%	89%	89%	14%
Discharged	16%	14%	13%	14%	16%	0%
Client-rated Alliance	31.4	39.2	39.4	39.6	39.8	27%
Team ACT Fidelity Score	4.0	3.8	4.0	4.0	4.0	0%

<u>Client Outcome (Follow-up)</u>	1997	2001	2002	2003	2004	% change 2004-1997
BPRS Observed symptoms	-7%	-10%	-10%	-13%	-14%	100%
BSI Reported symptoms	-6%	-10%	-11%	-13%	-13%	117%
Instrumental Functioning	1%	3%	2%	3%	3%	167%
Quality of Life reported	8%	10%	10%	10%	10%	25%
Housing Independence^		14%	13%	14%	13%	-6%
Satisfaction w/ MHICM (1-5)	3.7	3.7	3.7	3.7	3.7	1%
Change Inpatient days (6mos.)	-50	-42	-35	-33	-30	-39%
% Change Inpatient days (6mos.)	-64%	-73%	-72%	-72%	-71%	11%

* 71 of 78 teams in operation had sufficient data to be included in the FY 2004 report.

Remaining values for this table reflect those sites.

^ Introduced in FY 1999 Report.

End of MHICM 8th National Performance Monitoring Report - FY 2004

END OF FY 2004 MHICM PERFORMANCE MONITORING REPORT